Office of the Inspector General

SEMIANNUAL REPORT
TO CONGRESS

October 1, 1997 - March 31, 1998

U.S. Office of Personnel Management

OIG-SAR-18
April 1998

April 30, 1998

Honorable Janice R. Lachance
Director
U.S. Office of Personnel Management
Washington, D.C. 20415

Dear Ms. Lachance:

I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period October 1, 1997 to March 31, 1998. This report describes our office's activities during the past six-month reporting period.

Should you have any questions about the report or any other matter of concern, please do not hesitate to call upon me for assistance.

Sincerely,

Patrick E. McFarland
Inspector General

Table of Contents

Message From the IG

It has long been my conviction that the success of this office rests largely on the extent to which we can maintain our independence and objectivity while working as a team with our clients, both within and outside the agency. I am particularly pleased by the range of collaborative working relationships we have been able to establish without in any way diminishing our ability to exercise our professional judgment impartially and objectively.

This has been particularly true with regard to our health-care provider administrative sanctions program, which reflects a collaborative effort between the OPM program and the debarment program of the Office of the Inspector General (OIG) at the Department of Health and Human Services (HHS). Since 1993, our office has been using a regulatory structure known as the nonprocurement debarment and suspension common rule to assure that health care providers who have been excluded from Medicare by the HHS are also denied participation in the Federal Employees Health Benefits Program (FEHBP). Since these providers have already been afforded constitutionally required due process procedures and a right of appeal by HHS, the common rule authorizes the subsequent OPM debarments with a relatively brief notice and administrative review procedure. In this manner, with a modest level of resource involvement, OPM has been able to extend to FEHBP and its subscribers a tangible measure of protection against providers who have acted illegally or improperly. In turn, the HHS exclusion actions are given a substantial additional measure of impact, especially among health care providers whose Medicare clientele may not represent a large part of their practice.

The cooperation of HHS with OPM's debarment program has extended far beyond the common rule. Since the two programs have similar objectives and are directed toward many of the same providers, we have used the HHS debarment law and regulations as models for developing a working program for the FEHBP. As noted elsewhere in this report, we are hopeful that favorable congressional action will soon be forthcoming to improve OPM's statutory debarment authority. This will mark the culmination of nearly a decade-long effort on our part, and will give OPM the workable authority it needs to impose debarment directly against providers who have lost their licenses, committed crimes or violated FEHBP rules, even if they have not previously been sanctioned by another agency.

HHS's OIG has worked with us in creating a viable debarment program under the common rule and in providing the model for revised OPM statutory authority. As we note in the statutory section of this report that follows, it has also allowed our debarment staff to work with its staff to gain an understanding of the operational aspects of an independent debarment program. This was climaxed with a month-long detailing of our debarment staff, where they gained hands-on knowledge of how to operate this program. We are grateful for the generous manner in which the HHS OIG's office has shared its experience and time with our staff. We are committed to using the enhanced statutory authority in a manner that will further the interests of both the government and the public in safeguarding the integrity of health care systems.

.

Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds $78,792,665

Recoveries Through Investigative Actions $921,119

Management Commitments to Recover Funds $10,201,674

Note: OPM management decisions for recovery of funds during this reporting period reflect amounts covering current and past reporting period audit recommendations.

ACCOMPLISHMENTS:

Audit Reports Issued 19

Investigative Cases Closed. 22

Cases Accepted for Prosecution 5

Indictments 5

Convictions 12

Hotline Contacts and Complaint Activity 1093

Health Care Provider Debarments and Suspensions 1438

Evaluation and Inspections Reports Issued 2

Statutory and Regulatory Review

As is required under section 4 (a)(2) of the Inspector General Act of 1978, as amended, our office monitors and reviews legislative and regulatory proposals for their impact on the Office of the Inspector General and the Office of Personnel Management (OPM) programs and operations. Specifically, we perform this activity to evaluate their potential for encouraging economy and efficiency and preventing fraud, waste and mismanagement. We also monitor legal issues that have a broad effect on the Inspector General community and present testimony and other communications to Congress as appropriate.

During this reporting period, the Congress moved closer to final approval for independent sanctions authority for OPM. The House passed H.R. 1836, containing such provisions, and the Senate has begun consideration of that bill. In anticipation of eventual favorable action in this area, our office's administrative sanctions staff began a developmental training program at the Department of Health and Human Services. Our office's activities related to these subjects are described in the following articles.

Legislative Review

Bill With Administrative Sanctions Provisions Passes House

On November 4, 1997, H.R.1836, the Federal Employees Health Care Protection Act of 1997, passed the House of Representatives and was sent to the Senate, where it is currently under consideration by the Subcommittee on International Security, Proliferation, and Federal Services of the Committee on Governmental Affairs. Section 2 of this bill contains provisions that would enable OPM to issue debarment orders against health care providers who have acted improperly with regard to the FEHBP after an agency-based proceeding. The sanction would remain in place during subsequent administrative and judicial appeals. Our office, in cooperation with OPM's Office of Congressional Relations and Retirement and Insurance Service (RIS), participated in drafting this portion of the legislation and also consulted at some length with members of Congress and their staffs, as well as committee and subcommittee staffs and health care interest groups, during its consideration by the House.

As we have indicated in several prior semiannual reports, procedural impediments to rendering sanctions orders have made the existing FEHBP sanctions law not only infeasible but cost-prohibitive to operate. While these procedures in general are far more stringent than those applied to other federally funded health care programs, the most problematic aspects involve the proviso that all levels of both administrative and judicial appeal be exhausted before any sanction order can become effective. Overall, we consider the lack of a feasible, statutorily based administrative sanctions authority to present a serious shortcoming in the ability of the agency to protect FEHBP plans and subscribers from providers who pose a risk to their financial and health care interests.

OIG Directs Efforts Toward Passage of Health Care Sanctions Legislation

Administrative Sanctions Update

Pending enactment of legislation with administrative sanctions provisions, such as those referenced in the prior article, OPM has no workable statutory vehicle for taking direct action against health care providers who act improperly or illegally against the FEHBP. However, to partially mitigate this resultant vulnerability, our office has continued to use the government-wide regulatory program established under the nonprocurement debarment and suspension common rule (common rule) to debar from participation in the FEHBP any health care provider who has been the subject of prior sanctions by another federal health care program, such as Medicare. These "common rule" actions, however, do have significant shortcomings, including the fact that they do not permit civil monetary actions to recover funds improperly paid, nor can they be used to sanction providers who have been identified with FEHBP fraud unless there is an existing sanction from another federal agency.

During the reporting period, we issued 1,438 common rule debarments, a level of activity that continues a trend of substantially increased production during the past 18 months. In addition, our office is preparing for prompt implementation of a statutory sanctions authority that would result from passage of such authorizing legislation during the current session of Congress. As an initial step, with the assistance of the Office of the Inspector General at HHS, members of our staff have begun developmental assignments with that office's health care administrative sanctions component, which is responsible for imposing sanctions under the Social Security Act, particularly those involving the Medicare program. Inasmuch as Section 2 of H.R. 1836 is modeled on the Medicare exclusion statute, we anticipate that the knowledge, methods and procedures we obtain in the context of these training assignments will be directly applicable in structuring our own sanctions program.

OIG *Issues 1,438 "Common Rule" Sanctions Program Debarments*

Audit Activities

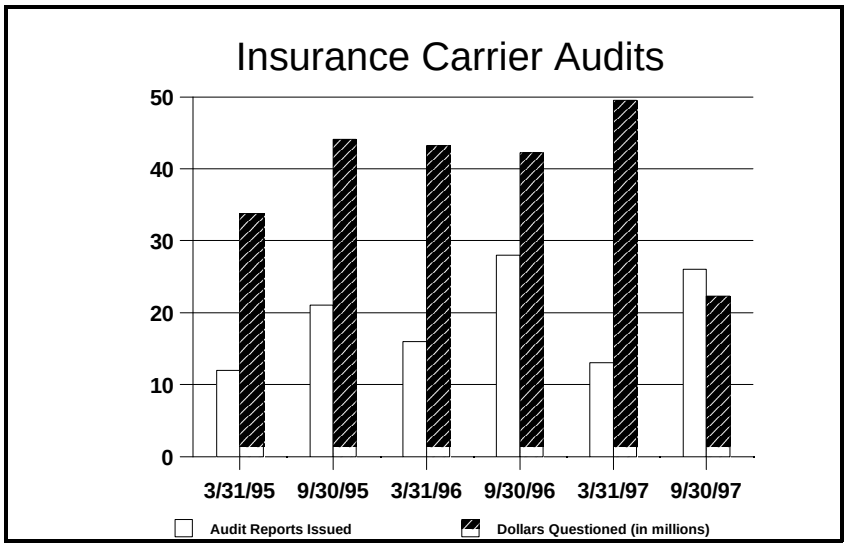
Health and Life Insurance Carrier Audits

The Office of Personnel Management contracts with private sector firms to underwrite and provide health and life insurance benefits to federal employees, annuitants, and their dependents and survivors through the Federal Employees Health Benefits Program and the Federal Employees' Group Life Insurance program (FEGLI). Our Office of Inspector General is responsible for auditing their activities.

Our audit universe contains approximately 565 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations, as well as two life insurance carriers, all of which share in annual premium payments in excess of $16.9 billion.

During the current reporting period, we issued 12 final reports on organizations participating in the FEHBP, 11 of which contain recommendations for monetary adjustment in the aggregate amount of $75.6 million due the FEHBP. One of the reports did not contain any recommendation for monetary adjustment. We also conducted a limited review on the use of preferred provider organizations (PPOs) within the FEHBP. In addition, we issued one report on the insurance company that holds the FEGLI contract in which we questioned $3.2 million. A complete listing of all these reports is provided in Appendix III on pages 57-58 of this report.

We believe it is important to illustrate the dollar significance resulting from our audits of FEHBP carriers and what this means to the FEHBP trust fund. For instance, during the past six semiannual reporting periods, the OIG issued 116 reports and questioned $235 million in inappropriate FEHBP charges as the graph below illustrates.



The sections that immediately follow explain the differences among the types of FEHBP carriers and provide audit summaries of significant final reports we issued during the past six months.

Community-Rated Plans

Within the community-rated, comprehensive medical plans, also known as health maintenance organizations (HMOs), we audit approximately 450 rating areas. A community-rated carrier generally sets the subscription rates for benefits on the basis of an average revenue requirement for each member. Under current statutes for HMOs, subscription rates can vary from group to group as the result of adjustments for factors such as the age and sex distribution of a group's enrollees (community rating by class) or its projected utilization of benefits (adjusted community rating). However, once a rate is set, it may not be adjusted to actual costs incurred or actual utilization. The inability to adjust to actual costs or utilization distinguishes community-rated plans from experience-rated HMOs, indemnity, or service benefit plans.

For the period 1991 through 1994, regulations required that subscription rates charged to the FEHBP be equivalent to the rates charged those two subscriber groups closest in size to the FEHBP and whose respective contracts contain similar benefits. In 1995, the provision requiring similar benefits was eliminated. These similarly sized subscriber groups are called SSSGs. Under these regulations, each carrier must certify that the FEHBP is being offered equivalent SSSG rates by submitting to OPM a certificate of accurate pricing. These rates are determined by the FEHBP-participating carrier, which has the responsibility of selecting the two groups that qualify as SSSGs. During an audit, should our auditors determine that equivalent rates were not applied to the FEHBP or that the appropriate SSSGs were not selected, then a condition of defective pricing (DP) exists. The FEHBP is entitled to a downward rate adjustment to compensate for any overcharges resulting from DP.

During this reporting period, we issued four audit reports on community-rated plans. The following summary of one of these HMO audits issued during the current period illustrates a number of problems encountered in applying and enforcing community-rating principles within the FEHBP.

TakeCare Health Plan of Ohio, Inc. in Cincinnati, Ohio

Report No. R8-00-96-031

January 22, 1998

TakeCare Health Plan of Ohio, Inc. (TakeCare) is a community-rated comprehensive medical plan providing health care services to its members throughout southern Ohio and northern Kentucky. During the five-year period covered by the audit, the FEHBP was one of the largest groups TakeCare served. For this period, the FEHBP paid premiums amounting to $73 million. Ownership of TakeCare changed several times during the audit period, the last

taking place in June 1994 when TakeCare was acquired by FHP International Corporation (FHP). In 1995, FHP formally changed TakeCare's name to FHP of Ohio, Inc.

Our audit of TakeCare covered contract years 1991 through 1995. We examined the plan's federal rate submissions and related documents to determine whether the FEHBP had received equitable treatment regarding market price rates. As a result, we found that the plan's certificates of accurate pricing were defective due to rating inconsistencies between the FEHBP and other similarly sized subscriber groups. Questioned costs to the FEHBP resulting from defective pricing for those years totaled over $8.28 million, including $1.7 million in lost investment income. In addition, TakeCare inappropriately applied a Medicare loading (credit adjustment) to the FEHBP's rates in 1991, which resulted in the FEHBP underpaying the plan $11,870 that year.

Premium Rates

In reviewing premium rates for these years, our auditors determined that for each year covered by our audit, the plan designated one or both SSSGs inappropriately. In 1991, one of the two SSSGs selected by TakeCare in its rate reconciliation received a 12.8 percent discount not granted to the FEHBP. The discount occurred because one of the demographic factors [projected average family size (AFS)] used by the plan to calculate the SSSG's rate was significantly lower than that derived from actual in-force AFS demographics. The plan could not provide any justification for the lowered AFS. Final calculations showed the FEHBP was overcharged about $1.4 million in 1991. TakeCare disagreed with our finding, contending we did not use the appropriate SSSGs and that the projected demographics it had used were reasonable.

We also disagreed with the plan's SSSG selections in 1992. One group terminated its contract during the rating year. The other was rated using a methodology different from the methodology used to rate other groups, including the FEHBP. We determined that it was not feasible to re-rate the FEHBP using that methodology. As a consequence, we selected the next two groups closest in size to the FEHBP as SSSGs. In reviewing the rates of one of these SSSGs, we found that it had received a 19 percent discount not afforded the FEHBP due to the same AFS demographic factor problem cited in our 1991 audit findings. TakeCare objected to the selection of the latter group as an SSSG, because it had two separate contracts (one for its hourly division and one for its salary division). The plan's position was that this latter fact disqualified the group as an SSSG. TakeCare also contended that neither contract with this group was shown to have a substantial market-place advantage. We disagreed with the plan on both points. Our review of the rates for the two contracts when compared to those for the FEHBP showed that one was overcharged and the other received a discount. Based on our calculations, the net discount was 18.7 percent, resulting in an overcharge of $2.9 million to the FEHBP in 1992.

For 1993, we agreed with one of the plan's SSSG selections and found that it was rated correctly. However, we disagreed with the plan's other SSSG selection and determined that the correct SSSG was the same group we had selected and TakeCare objected to in 1992. Our review of this group's rates showed that the plan once again used unreasonable AFS projections in determining its rates. We also noted that the plan provided benefits to the

FEHBP but did not charge for them. The net discount amounted to 3.3 percent or a $516,000 overcharge to the FEHBP. The plan disagreed with the finding, based on our SSSG selection.

Defective Pricing Results in $8.28 Million Loss to FEHBP

Again in 1994, we disagreed with one of TakeCare's SSSG selections, determining that the SSSG should have been the same group we selected over the plan's objections in 1992 and 1993. The 4.4 percent discount we noted was a result of the plan's continued use of unreasonable AFS projections previously noted for contract years 1991, 1992, and 1993. In addition, we also found that TakeCare had contracted with another company to administer the activities of the plan for the SSSG employees. The company charged a fee totaling one percent of the monthly premiums for this service, which the SSSG subtracted from the premiums submitted to the plan. We viewed this as an additional discount to the SSSG, since the plan paid the contractor for administering the SSSG contract. After subtracting 1.5 percent to give the plan credit for benefits provided but not charged to the FEHBP, the SSSG's total rate advantage was 3.9 percent. This equated to a $682,000 overcharge to the FEHBP in 1994. The plan disagreed with this finding in terms of the SSSG selected as well as our position regarding the contract fee.

TakeCare did not select the appropriate SSSGs in 1995. After determining the proper SSSGs, we found that both received discounts. The larger SSSG discount went to a government group that received a rating methodology different from that used for calculating the FEHBP's rates. To ascertain what pricing disadvantages to the FEHBP might have resulted from this situation, we re-rated the FEHBP using the same experienced-rating approach used to rate the SSSG, including the same experience period, trend factor, and administrative charges. We also factored in the cost of extra benefits the plan provided the FEHBP at no additional cost. We compared the audited rates to the rates charged the FEHBP and determined that the audited rates were over $1 million lower in favor of the SSSG. The plan agreed that the FEHBP is due this amount.

Lost Investment Income

In accordance with the FEHBP contract with community-rated carriers, the FEHBP is entitled to recovery of lost investment income on defective pricing findings. As a result, we determined that the FEHBP is due over $1.7 million in lost investment income through December 31, 1996. An additional amount is due for the period beginning January 1, 1997, until all funds have been returned to the FEHBP. TakeCare disagrees that lost investment income is due for 1991 through 1994, since it disagrees with the findings in those years. For 1995, the plan said that it is still waiting for the outcome of pending litigation that questions OPM's authority to collect lost investment income before making any further response.

Lost Investment Income Due FEHBP Totals $1.7 Million

Experience-Rated Plans

In addition to community-rated plans, the FEHBP offers a variety of experience-rated plans, including the Government-wide Service Benefit Plan, those plans sponsored by employee organizations, and comprehensive medical plans (experience-rated HMOs). An experience rate is a rate that reflects a given group's projected paid claims, administrative expenses, and retentions. Each carrier maintains separate accounts for its federal contract, and future premiums are adjusted to reflect the federal enrollees' actual past use of benefits.

Audits of these plans generally focus on the allowability of contract charges and the recovery of appropriate credits, the effectiveness of carriers' claims adjudication systems, and the adequacy of internal controls to ensure proper contract charges and benefit payments.

Government-Wide Service Benefit Plan

As mentioned in the introduction to the Service Benefit Plan section of this report, the BCBS Association has established a Federal Employee Program Director's Office in Washington, D.C., that provides centralized management for the Service Benefit Plan. This office coordinates the administration of the Service Benefit Plan contract.

The purpose of our audit was to determine if all administrative cost charges to the FEHBP were in accordance with the terms of the contract and federal regulations. As a federal contractor and as a participant in the FEHBP, the Director's Office has a unique responsibility to the government and to the FEHBP subscribers to conduct its business in a cost-effective manner. With this in mind, our auditors looked at four major categories of administrative expenses and found questionable costs in each as follows: $7,111,414 for marketing; $2,471,149 for meetings and conferences; $31,786 for professional services; and $2,267,189 for miscellaneous items. These unallowable administrative expenses totaled $11,881,538. We also calculated an additional $3,982,018 in lost investment income on the audit findings presented in the report. Federal regulations require carriers to pay lost investment income on all unallowable, unallocable and unreasonable contract charges.

Auditors Calculate $15,863,556 Owed to the FEHBP

Our auditors examined the BCBS accounting statements pertaining to the BCBSA for contract years ending December 31, 1991, 1992, 1993, and 1994. We selectively reviewed administrative expenses charged during these years. Some of our major findings resulting from this audit are summarized below.

Marketing

Unallowable marketing salaries From 1991 through 1994, the FEP Director's Office in Washington charged the FEHBP for salaries and benefits for marketing department employees. As a result of our audit, we determined that this office had 23 to 25 employees dedicated to enhancing the image of Blue Cross and Blue Shield and increasing the Service Benefit Plan's market share in the FEHBP. In accordance with the Federal Acquisition Regulation (FAR), the costs of these activities cannot be charged to the FEHBP contract. This finding was based on a review of the work performed and actual position descriptions of marketing department employees. We noted that key functions described in these position descriptions ranged from image enhancement of BCBS to developing and coordinating the annual marketing plan for FEP with respect to goals and objectives for the next FEHBP open season (a specified time frame occurring once a year when federal employees and retirees are given the opportunity to change health insurance plans). The BCBSA contested our finding, stating that a portion of these salaries were allowable under federal regulations. However, we noted that, on average, the association charged 90 percent of the marketing department employees' salaries to the FEHBP in 1991 and 1992 and 85 percent in 1993 and 1994. Further, the association was unable to provide any additional documentation to support the salary allocations for these marketing employees. As a result, we recommended that the OPM contracting officer disallow $4,328,337 for these unallowable salaries and benefits.

Marketing planning meetings The FEP Director's Office charged the FEHBP for meals,

lodging, airfare, production and other miscellaneous costs relating to its marketing planning meetings from 1991 through 1994. We believe that the primary purpose of these meetings, which involved extravagant banquets and elaborate video and audio productions, special promotions, and live entertainment, etc., was to increase enrollment in the BCBS Service Benefit Plan. Federal regulations prohibit costs associated with increasing enrollment in the FEHBP. We also noted that another contract criterion--that costs charged to a government contract be reasonable and necessary--was not met. For instance, the Director's Office spent $277,000 on food and alcoholic beverages at these meetings, of which more than three-fourths was charged to the federal government. This was far in excess of the allowable meal per diem. Production costs during this time frame were over $315,000, with $251,000 charged to the FEHBP.

It is also significant that the U.S. Senate Permanent Subcommittee on Investigations reviewed these and other BCBSA-sponsored meetings during this period of time. Subcommittee investigators compared these meetings to conferences and meetings held by other fee-for-service FEHBP plans and concluded that none of the other plans held meetings comparable in nature or expense. They questioned whether the federal government should pay for staging and producing such elaborate events and determined that the costs did not pass the reasonableness test.

Questioned Costs Include $7,111,414 for Marketing Expenses

The association contested our finding, stating that the primary purpose of the events was to disseminate information, discuss long-range planning, and prepare for open season. Based on our review of the information available regarding the focus and intent of workshop and general meeting sessions and all associated expenses surrounding these marketing planning meetings, we recommended that the contracting officer disallow $434,727 for meals, lodging, airfare, production, and other miscellaneous costs.

Other marketing-related expenses we recommended be disallowed were as follows: marketing training costs ($272,085); regional marketing planning meetings ($173,560); promotional items ($158,737); open season benefits video ($92,717); and advertising ($97,951). Out of all these administrative expenses, BCBSA only agreed with the finding relating to advertising costs, saying that this expense was inadvertently charged to the FEHBP.

Meetings and Conferences

FEP national conferences. As with the marketing meetings described in the previous finding, the FEP Director's Office inappropriately charged the FEHBP for expenses relating to meals, lodging, airfare, production and other miscellaneous costs. The Director's Office sponsors the annual FEP national conferences, inviting approximately 500 representatives from BCBS local plans. For the contract years audited, we noted that these conferences were held in New Orleans, San Diego, Atlanta, and Palm Springs. Without exception, these conferences could only be characterized as exceptionally elaborate. For instance, the 1992 conference took place in New Orleans. Festivities included a riverboat gambling party and a Mardi Gras celebration. The total cost was over $54,000 for these events, with the federal

government being charged $25,000 of this amount for travel, transportation, costumes, and a cruise on the riverboat. The conference also featured an appearance by Olympic gymnast Peter Vidmar, including a pommel horse demonstration and autograph/photo session. The government paid over $4,600 for this service.

With respect to national conference-associated meals, the FEHBP was charged $429,000 during this four-year period. Meals consisted of breakfast, lunch and coffee breaks, as well as evening banquets and special events and a formal dinner dance for the awards ceremony. In addition, we determined that some of the workshops centered around unallowable marketing activities, such as image enhancement. For that reason, we questioned all production costs, food costs that exceeded the per diem, and a percentage of the remaining costs (meals, lodging, travel, airfare and miscellaneous costs) relating to these marketing workshops. Our auditors calculated that $1,647,772 in unallowable, unreasonable or unnecessary expenses had been charged to the FEHBP during this period. BCBSA contested all but $60,049 of this amount, which represented expenses related to certain entertainment and workshop activities.

$2,471,149 Disallowed for Conference & Meeting Expenses

Meals and expenses above per diem. Our review of meeting facilities showed that the association charged the FEHBP costs in excess of per diem limits. The FAR limits travel cost to the per diem rates for federal employees. At conferences involving local plans, the plans typically charge per diem and airfare, while the Director's Office charges meals and other expense to the FEHBP. This arrangement resulted in an overcharge of $609,031 to the FEHBP from 1991 through 1994. At conferences, training seminars, and board meetings, BCBSA usually pays for all meals and charges the expenses to the FEHBP. Meeting attendees from local plans are normally responsible for their own airfare, lodging, ground transportation and incidentals. These costs typically exhaust the allowable per diem, and, therefore, any expenses charged by BCBSA are unallowable. In light of our finding, we also recommended that the contracting officer direct the association to implement procedures to prevent travel costs for employees of either a local plan or the association to exceed the allowable per diem.

Local meetings. We found that the FEP Director's Office incurred unreasonable expenses when organizing local meetings. The Director's Office charged the FEHBP excessive amounts for meetings at local hotels even though there were at least 15 conference rooms of varying sizes at the Director's Office location, some of which would have easily accommodated these meetings and seminars. Some specific examples of unreasonable expenses charged to the FEHBP included using high-priced hotels for routine business meetings (employee meetings, team building meetings, training seminars, etc.); excessive food and drink costs at the meetings; renting hotel rooms for consultants exceeding $240 per day; and various miscellaneous costs, such as bartender charges, tax on alcohol, and excessive gratuities. We determined unallowable expenses in connection with these local meetings to be $214,346 over the four years covered by our audit. The association disagreed with all but $1,836 of this amount. We recommended to the contracting officer that the full amount we questioned be returned to the FEHBP.

Audit services. The FEP Director's Office improperly charged the FEHBP for its annual audit performed by an independent public accounting (IPA) firm. The audit included a review of the service charge account, a non-FEHBP fund, for the 1991-1994 period. Federal regulations do not permit charging this work to the FEHBP because it is unrelated to its contract with BCBSA. We learned that 20 percent of the audit time was spent on the account in question, making the FEHBP eligible to recover $29,557 for this overcharge. The association did not contest this finding.

Service mark litigation. In August 1991, the Director's Office charged the FEHBP $2,229 for a review of a finding from a prior audit. This is in violation of the federal regulation that prohibits incurring a directly associated cost that is based on a previously unallowable cost, as was the case in this instance. The association also did not disagree with this finding.

Miscellaneous Expenses

Overhead costs. These expenses included unallowable overhead costs totaling $1,857,250 for such items as office rent, telephones, office maintenance and supplies, equipment and computer rent, property insurance and taxes, etc., because they were considered directly associated costs to an unallowable expense (marketing).

Personal travel costs. We questioned other expenses related to employee personal travel amounting to $263,111. The Directors's Office had an established policy that permitted an employee to use the difference between full coach fare and whatever reduced fare an employee actually received as a personal travel expense chargeable to the FEHBP. This policy is contrary to federal regulations that only permit official company business as an allowable expense and only the actual rate charged, discounted or otherwise.

We also questioned two other expenses: a chapter in the Taking Care of Your Child book that the contract stipulated could not be included ($85,458), and certain entertainment expenses for holiday and retirement parties, luncheons and picnics ($61,370).

Unallowable Miscellaneous Expenses Total $2,267,189

Empire Blue Cross and Blue Shield in New York City and Albany, New York

Report No. 10-48- 95-022

February 13, 1998

Our audit of the Empire Blue Cross and Blue Shield plan (Empire) was held in New York City, as well as its Albany, New York location, and covered contract years 1990 through 1994. We examined administrative expenses and health benefits financial data for those years, questioning $3,958,211 in inappropriate costs to the FEHBP as a result of our findings.

In conducting this audit, our objectives were to determine whether Empire had charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract and applicable regulations. In particular, we wanted to see if incurred administrative expenses were actual, necessary and reasonable, whether the plan's financial accounting procedures properly accounted for FEHBP monies, and if credits accruing to the plan for FEHBP claims payments were returned promptly.

These findings and questioned costs for this audit fall under the following categories: administrative expenses ($239,007), financial accounting and supplementary payments ($805,807), cash management ($2,146,776), and lost investment income ($766,621). Some of the more significant findings are listed below.

Audit Findings Result in Questioned Costs of $3,958,211

Administrative Expenses

To test the plan's compliance regarding administrative expenses, we examined a selection of administrative expenses for the four contract years 1991-1994, using the FEHBP contract, the Federal Acquisition Regulation, and the Federal Employees Health Benefits Acquisition Regulations. We also interviewed Empire personnel and analyzed cost accounting documents to gain an understanding of controls over allocating administrative cost to the contract.

Unallowable/unallocable costs Empire included unallowable and unallocable costs in its cost submissions to the BCBSA's FEP Director's Office. This occurred because the internal controls in place did not properly identify and remove these costs. The result was an inappropriate charge to the FEHBP of $86,905. The association agreed with our finding and has now implemented procedures to improve identification of costs that are unallowable or unallocable.

Provision for unpaid claims. Empire charged the FEHBP for an account called "Provision for Unpaid Claims" in 1990, 1991, and 1994. This account was used to forecast the cost of processing unpaid claims. The FEHBP contract and federal regulations clearly state that costs incurred by the FEHBP must be actual, necessary and reasonable. By definition, forecasted costs are unallowable. After certain year-end adjustments were made by the plan to this account in 1994, there remained $59,443 in unallowable costs to the FEHBP. The plan agreed with only a small portion of our finding but, to date, has been unable to document that an adjustment of $49,631 was made to this account at the end of 1991. We, therefore, have recommended that the contracting officer disallow $59,443.

Empire agreed with our findings regarding disallowed costs to the FEHBP in all the remaining areas we examined. These are: cost submission variances in the accounting system, resulting in overcharges to the FEHBP ($42,544); inappropriate legal services charges, including unallowable legislative lobbying expenses ($37,313); incorrect BCBSA dues computations ($8,896); and incorrect computations regarding FEHBP's share of allowable cost of capital ($3,906).

Inappropriate Administrative Expenses Total $239,007

Health Benefits Financial Data
& Supplementary Payments

Hospital utilization review adjustments. The plan did not have procedures in place to guarantee prompt credit to the FEHBP for refunds resulting from hospital utilization reviews. We found that refunds totaling $419,198 were not refunded to the FEHBP on time (i.e., within 60 days) and an additional $279,190 in refunds had not been credited as of August 22, 1995. These delays have resulted in lost investment income opportunities for the FEHBP of $47,057 on those amounts. Since the $279,190 remains outstanding, our total questioned costs, including lost investment income was $326,247. The Blue Cross and Blue Shield Association has stated that the plan has now implemented procedures to ensure prompt processing of adjustments.

Uncashed checks. Empire did not void and return outstanding FEHBP benefit checks in the two-year time frame required by the contract. The uncashed checks eventually were returned in 1993, 1994, and 1995 and totaled $1,895,438. We calculated the amount of lost investment income to the FEHBP to be $239,289.

Write-off of FEP accounts. In 1990, Empire should have credited the FEHBP for outstanding credit balances in FEP line of business accounts. Instead, $221,317 was written off in error to the plan's own miscellaneous income account during accounting reconciliation activities. We recommended the return of this amount to the FEHBP and that the contracting officer direct the plan to implement controls to avoid problems of this kind in the future.

Unapplied cash write-offs. The plan did not credit the FEHBP for its share of unapplied cash deposits in 1990 and 1993. Instead, these cash deposits were written off as miscellaneous income for the plan. We did note, however, that in 1992 the plan did properly credit the FEHBP for its prorated share that year. For contract years 1990 and 1993, we calculated the FEHBP's prorated share to be $18,954 and have asked the contracting officer to direct the plan to credit this amount to the FEHBP. The association agreed with this finding and stated that cash controls are now in place to correct this problem.

Provider advances. These advances are intended to pay for hospital care more quickly and improve hospital cash flow. They are necessary because there is a time gap between the date hospitals provide services and when they are actually paid for them.

The Blue Cross Blue Shield Association's own internal policy requires a semiannual reassessment of provider advances and written confirmation of each review. We noted during this audit that Empire had advanced $3,044,386 of FEHBP funds to providers and yet has not reviewed or adjusted that amount since 1992. With the current trend toward increasing electronic claims filing and funds transfers, the need for advances may be somewhat diminished. We found further that the majority of hospitals within the state of New York file claims electronically, and that provider advances may be overstated. We believe that this situation could

result in lost investment income for the FEHBP.

Questioned Financial Data & Supplementary Payments Total $805,807

Cash Management

Cash management. Our auditors determined that the plan did not properly manage FEHBP funds. Because of Empire's reimbursement arrangements for FEHBP claims, it had maintained excess FEHBP funds. Federal regulations require that these funds be held in separate income-bearing accounts and that the plan credit interest earned on any excess FEHBP funds to the FEHBP. These requirements are located in 48 CFR 1652.232-72 and 48 CFR 1652.215-71, respectively. The plan's failure to honor either stipulation has resulted in lost investment income opportunities for the federal government for which it is entitled to be compensated. Based on statistical analysis using an experience-rate for the average number of days FEHBP money has been held by local BCBS plans, we determined that the FEHBP had lost $2,146,776 in investment income from 1992 through 1994. We have recommended to the contracting officer that Empire return this amount to the FEHBP.

In a related matter, and as we mentioned in our last semiannual report, the BCBS Association previously used the FEHBP letter of credit (LOC) account to reimburse these local plans one day after claims have been processed. The LOC account was created to improve the cash management of FEHPB funds and to maximize investment income for the FEHBP. It was intended to operate on a checks-presented" basis, meaning that BCBS plans would receive their reimbursements at the time their checks were actually presented to the bank. At the time of this audit, this account was managed by the BCBS Association. Now, it is managed by local BCBS plans.

Plan's Cash Management Costs FEHBP $2,146,776

Lost Investment Income

In accordance with FEHBP contract language, all carriers are required to invest and reinvest all excess FEHBP funds on hand and to credit all investment income earned on those funds to a special reserve fund on behalf of the FEHBP. When this does not occur, as was the case with several of our findings during the course of this audit, we must determine the amount owed to the FEHBP. In this instance, we calculated an amount of $766,621 plus any interest accruing after December 1996.

FEHBP Due $766,621 in Lost Investment Income

Employee Organization Plans

These plans also fall in the category of experience-rated and may operate or sponsor partici-

pating health benefits programs. Employee organization plans operate on an indemnity and fee-for-service basis. Members are free to obtain treatment through facilities or providers of their choice for which claims are submitted to the carrier for adjudication and payment.

During the reporting period, we issued three employee organization plan audit reports and one special review report for Congress. One of the employee organization reports and the special review report are summarized in the following narratives.

Continental Assurance Company & Claims Administration Corporation as Underwriter for the Mail Handlers Benefit Plan in Chicago, Illinois, and Rockville, Maryland

Report No. 45-09--93-001

March 19, 1998

Continental Assurance Company (Continental) in Chicago, Illinois, and its affiliate, the Claims Administration Corporation (CAC) in Rockville, Maryland, served as underwriter/ administrator for the Mail Handlers Benefit Plan (MHBP) for the period of this audit (1987-1991). The audit covered health benefit payments made during 1991 with one exception and administrative expenses for 1987 through 1991. During this period, MHBP contracted underwriting services, including claims processing, to Continental. In turn, Continental subcontracted the administrative functions of the contract to CAC.

The primary purpose of the audit was to determine if costs charged to the FEHBP during this period were in accordance with the terms of the contract MHBP had with OPM. We examined health benefits claim charges for 1991, and later expanded our audit to include one specific type of claim [first office visits (FOVs)] for contract year 1992. From 1987 through 1991, CAC paid over $5.1 billion in health benefits claims and Continental was reimbursed $474 million in administrative costs and premium tax payments. Our auditors questioned $33,194,149 for the period, including lost investment income of $10,532,160. The most significant findings in these areas are presented below.

Auditors Determine $33,194,149 in Total Questioned Costs

Health Benefits

To test transactions, procedures, and controls related to the FEHBP claims processing system at Claims Administration Corporation for contract year 1991, our auditors examined claims payments and reviewed a random sample, consisting of 450 health benefits claims chosen from a universe of 4.5 million claim records. While at CAC's Rockville headquarters, we also looked at claims-related issues, such as claim overpayments, refunds, uncashed benefits checks, as well as various underlying accounting policies and procedures.

First office visit charges. The FEHBP contract and the MHBP brochure both clearly state

that payment will be made for outpatient office visits beginning with the **second** visit by a covered member during a calendar year for illness, mental conditions, and substance abuse. This was a cost-containment feature of the plan. According to the contract, any changes for paying a benefit not within the specific benefit provisions of the contract had to be documented and justified in writing. Furthermore, such changes had to be cost-effective and in the best interest of the FEHBP. In March 1991, CAC changed its processing procedures to require application of the FOV exclusion only if the patient had no claim history or if the only charges in the history were for durable medical equipment, prosthetic appliances, dental or prescription claims. This nullified the FOV exclusion in many instances where it should have been applied. This change was made without OPM approval and proved to be one of the main reasons that, in 1991, $4,316,346 for first office visit claims was improperly paid.

Because of the importance of the FOV cost-containment issue, we expanded our audit to examine FOV claims for contract year 1992 as well. This revealed an additional $6,264,261 in FOV overpayments. Our agency's Office of Insurance Programs (OIP) determined that it was not feasible to collect the overpayments from the enrollees, because most of the claims were under $50 and at least three to four years old. However, because the FOV issue was not handled in accordance with the contract terms, OIP took the position that the FEHBP should be reimbursed for part of the overpayments. As a result of discussions between CAC and OIP, the plan agreed to refund $7,024,361 to the FEHBP trust fund.

Plan Agrees to $7,024,361 Claims Payment Refund to FEHBP

Administrative Expenses

Retention costs. Retention charges represent the costs of the operational support and general administrative services provided by the CNA Insurance Companies' home office to CAC, Continental, and/or the FEHBP. These indirect costs are in addition to costs charged to the FEHBP for CAC and Continental services. We found that the method used to allocate these costs was created specifically for the FEHBP contract and was not the standard corporate cost-allocation methodology. Based on our analysis, we believe that use of this methodology may have resulted in overcharges amounting to as much as $69.9 million during the years audited. In our opinion, the costs charged to the FEHBP have only a casual relationship to the benefits received. However, prior to the period of the scope of this audit, a consultant hired by OPM to review the cost-allocation methodology concluded that it was a reasonable alternative. Based on the consultant's findings, OPM approved this methodology. Consequently, the $69.9 million was not questioned except for $3,096,630 that Continental agreed was overcharged and has agreed to return to the FEHBP. In addition, Continental is developing a new cost-accounting system that will be applied on a company-wide basis. Our review of the concepts of the new system indicate that it will be a significant improvement over the current system.

Additional administrative overcharges. Other significant findings relating to overcharges for

administrative expenses include $1,532,390 for data processing costs, $1,044,174 for legal charges, and $814,277 related to cash paid out to employees for unused sick leave.

Unallowable Administrative Expenses Total $6,886,161

Premium Taxes

Premium tax overcharges. The audit showed that Continental overcharged the FEHBP $8,191,876 for premium taxes. The overcharge occurred as a result a 1990 accrual for taxes on uncollected premiums that was included in the calculation of Continental's total premium tax charges. The FEHBP portion of the $19,085,433 accrual amounted to $8,191,876, with MHBP's share being $7,572,570. As of January 1, 1991, FEHBP premiums were no longer subject to premium taxes, as provided for in P.L. 101-508. Consequently, the FEHBP portion of the tax was never paid. The accrual portion of the tax that was charged in 1990 should have been reversed in 1991, with a corresponding credit to the FEHBP. We found that while Continental did reverse the accrual on its corporate ledgers, the FEHBP was not allocated its share of the credit. Although Continental disagrees with this finding, we have found no evidence that the $8,191,876 accrual was ever returned to the FEHBP.

In another finding pertaining to premium taxes, we noted that Continental incorrectly charged the FEHBP $1,099,924 for Illinois premium taxes in 1989 and 1990. Continental is based in Illinois where domestic insurance companies are not required to pay Illinois premium tax. Continental agreed with this finding.

Lost Investment Income

As a result of the audit findings presented in the report, we determined that the FEHBP is due $10,532,160 for lost investment income from 1991 through 1997. An additional amount is due from January 1, 1998, until Continental credits all funds due the FEHBP. Continental said that it will pay lost investment income in accordance with the contract upon final resolution of the outstanding audit issues.

Premium Taxes & Investment Income Losses Cost FEHBP $19,283,627

Use of Silent PPOs in the Federal Employees Health Benefits Program Review

Report No. 99-00-97-054

February 26, 1998

As a result of interest initially expressed by Chairman John L. Mica, Subcommittee on Civil Service, House Committee on Government Reform and Oversight, our office performed a review of the use of "silent" and "non-directed" preferred provider organizations in the FEHBP. The subcommittee conveyed to us the concerns of the American Hospital Associa-

tion and the American Medical Association that some health care providers were and are being victimized by schemes that create payment discounts on services from doctors and hospitals to which payers (insurance carriers) are not entitled. During the course of our audit, we were also made aware that this issue was receiving attention at the full committee level as well. At the committee's request, we also determined how wording came to be included in OPM's annual carrier call letter that specifically encouraged FEHBP carriers to seek discounts on provider bills.

As a result of this review, we found no evidence in the FEHBP that "silent PPOs" were a factor or that provider discounts were otherwise taken on the basis of any schemes to victimize medical providers. Additionally, we found FEHBP carriers and their vendors were, except for minor exceptions, accessing discounts in accordance with the terms of their contracts with providers. Our review further disclosed that substantial savings have been and can be achieved by both directed and non-directed PPOs.

Insofar as OPM's call letter, we determined that the language in question was the result of discussions that took place sometime in early 1993 between the House Appropriations Committee staff and OPM's former Associate Director of Retirement and Insurance.

During that period, the committee was considering either report or statutory language to require FEHBP carriers to take advantage of provider discounts available in the market place. While OPM was opposed to having a directive from Congress that appeared to regulate the market place, the Associate Director for Retirement and Insurance suggested a compromise whereby language would be included in the agency's future annual call letters to encourage carriers to take advantage of whatever discount arrangements that were available in the market place. Thus, OPM's March 1993 call letter (for the 1994 contract year) and succeeding call letters to date contain such language. In their reports accompanying OPM's appropriations bills covering fiscal years 1994 and 1995, both the House and Senate Appropriations committees applauded this action.

OPM Carrier Call Letters Encourage FEHBP Cost Savings

Because of the complexity of the origins of the terms "silent PPO" and "non-directed" PPO and how they relate to our findings in this review, the following PPO background information, together with a discussion of the specific methodology we used and conclusions drawn during our review, are summarized below.

PPO Definitions and Background

During the last decade, the health insurance industry has been undergoing rapid change in response to rising costs. The ever increasing number of HMOs, which are able to control costs via utilization control and managed-care techniques, has caused fee-for-service carriers to seek better ways and means to control their costs to remain competitive. One cost control method used by the latter is a PPO. A PPO is a group of medical providers who agree to provide medical services to the subscribers of an insurance carrier at a lesser cost than otherwise would have been charged. In exchange for a preferred status, lower fees and better care, a carrier would attempt to steer its subscribers to the PPO's medical providers through such

methods as financial incentives, ID cards, and preferred provider lists. Thus, significant savings could be achieved by the carrier, leading to reduced premium costs.

Non-directed PPOs. In recent years, a new variation of the PPO concept has appeared. This variation is known as a "non-directed" PPO, which is different from the traditional "directed" PPO. These terms are simply references to the steerage or lack of steerage of patients. For instance, in a non-directed PPO, even though the medical providers have agreed to charge a lower fee, the contract the PPO enters into does not require the carrier's subscribers be "steered" to the providers. While some non-directed PPOs may benefit from this arrangement through prompt payments or advances, in other non-directed PPO arrangements, the benefits to the health provider may be less clear.

In the case of both directed and non-directed PPOs, their business arrangements are committed to a contract between parties. In most instances, there will be intermediate organizational layers between the insurance carrier and the medical providers. In a typical non-directed arrangement in the FEHBP, an insurance carrier contracts with a third-party vendor for non-directed PPO services. The vendor assembles the network of non-directed PPO providers either by contracting directly with individual providers or with networks of providers. These networks, in turn, contract with individual providers. Often these business arrangements appear complicated and confusing. For example, some insurance carrier clients use the vendors for directed PPO services, and thus share the same providers with other carrier clients who use the vendor's non-directed PPO services. Since the vendor may have only a single contractual agreement with the provider, some of the patients are steered and others are not.

Silent PPOs. Concurrent with the evolution of non-directed PPOs, a new term, "silent PPO" became commonplace. Its connotations are now, to a large degree, negative. Initially, it was merely a reference to a non-directed PPO where the contract was "silent" with regard to steerage of patients to a provider's facilities. More recently, the term has acquired a restrictive meaning synonymous with unethical and/or illegal practices. In contrast to a non-directed PPO, a "silent' PPO cannot trace a contractual relationship from the insurance carrier to the medical provider from whom the discount is taken. This practice involves the selling of provider names and the discounts they provide to third parties who access the discounts by misrepresenting their subscribers as members of the provider's PPO.

Methodology and Conclusions

PPO savings. In our 1997 survey of FEHBP carriers, we asked carriers how much the FEHBP saved by using directed and non-directed PPOs. Carriers reported substantial savings, the majority of which were realized under directed PPO arrangements. For the six-month period ending June 30, 1997, six carriers reported gross directed PPO savings totaling $390.5 million. For the same period, a different mix of six carriers reported gross non-directed PPO savings totaling $25.5 million. In view of the fact that directed PPOs provide for steerage of patients, savings attributed to this PPO group are substantially larger than non-directed PPO savings, which would be expected. Nevertheless, non-directed PPO savings are also significant and offer additional opportunities to reduce FEHBP costs. For that reason, savings from the latter should not be overlooked as long as they can be achieved

in an ethical and lawful manner.

No evidence of silent PPOs. Based on our test of insurance benefits paid in August 1997 by FEHBP carriers, we found no evidence that silent PPOs were used as a method of capturing discounts or that providers were being otherwise victimized. OPM regulations set forth minimum standards for health benefit carriers regarding prudent business practices that, by definition, must be not only legal but ethical. To search for the use of silent PPOs in the FEHBP, we focused our attention on the vendors who subcontract with FEHBP carriers to provide non-directed PPO services. As a result, we identified five FEHBP carriers, who contracted with four vendors to provide non-directed PPO services. These vendors also provided directed PPO services to other clients.

We sampled and reviewed 600 claim lines, representing 120 claim lines for each carrier, priced by these vendors. We determined that, while a series of contractual agreements were in place between the vendors, provider networks and providers, no evidence was found that these FEHBP carriers, through their vendors, used silent PPOs to access discounts. We further noted that the discounts taken, almost without exception, were consistent with the terms of their FEHBP contracts. In only eight of the 600 claim lines did we find that vendors had accessed provider discounts in a manner inconsistent with contract terms.

Review Finds No Silent PPOs Used to Capture Discounts

Concerns unfounded within FEHBP. While the evidence of our review suggests little cause for concern with respect to FEHBP carriers and their vendors, this conclusion is inconsistent with the level of concern expressed by the medical community regarding the overall problem of unethical business practices pertaining to silent PPOs. While we discovered no material instances within the above-cited sampling to support vendor indiscretion in allowing discounts to FEHBP carriers to which they were not entitled, all vendors for FEHBP carriers must bear the responsibility to make certain this never becomes a problem for the FEHBP or the medical providers that service FEHBP subscribers.

Unrealized provider expectations. Although we found that in the great majority of the cases, discounts taken were consistent with contract terms, the complex environment and sometimes vague contract terms under which PPOs operate may leave providers with unfulfilled expectations. We observed that many of the vendor contracts with provider networks and providers state that the vendor will make a reasonable or best effort to encourage insurance carriers to provide incentives to its subscribers to use the vendor's providers. However, best efforts do not always translate into actual steerage.

Life Insurance Plans

The FEGLI program was created in 1954 by the Federal Employees' Group Life Insurance Act (P.L. 83-598). The Act provides for two programs to be administered by two separate contracts. The first program, administered by the Shenandoah Life Insurance Company, pro-

vides life insurance to retired or otherwise separated federal employees who, on the effective date of the Act, August 11, 1955, received benefits from 27 separate federal employee benefit associations. The second program, administered by the Metropolitan Life Insurance Company, provides coverage to all who were or became federal employees after the effective date of the Act.

OPM's Retirement and Insurance Service has overall responsibility for administering the two federal life insurance programs. Our office audits the insurance companies to ensure that they are administering their contracts in accordance with federal law and all other pertinent regulations.

During this reporting period, we issued one report regarding the FEGLI program contract.

Reengineering expenses. We determined that during 1995 MetLife charged the FEGLI program over $225,000 for company reengineering costs that did not benefit the program. MetLife's reengineering effort was designed to reduce costs and improve MetLife's processes in order to make it more competitive. These reengineering charges related to two major initiatives: one to improve MetLife's financial management and accounting systems, and the other to improve business operations. Our review of the financial management and accounting systems costs showed that the program did benefit from some of the improvements, such as capital management, reserves, general ledger, operational accounting, and asset and liability management. However, we also noted that charges totaling $30,577 related to improvements in the pricing of MetLife products did not benefit the program.

MetLife charged $399,695 to FEGLI for improvements to MetLife's business operations. Included in that amount was $195,196 that did not appear to benefit FEGLI and for which MetLife could not provide sufficient documentation. Unallowable charges related to such things as a special advertising project, a survivor counseling center, a laptop computer program, consumer education, bank financial services, and market and product innovations. Under federal regulations, a cost is not allocable to a government contract unless the contract derives some benefit from the costs incurred.

Unallowable department and cost center charges. We also found that MetLife charged the FEGLI program over $2.6 million in unallowable and/or unallocable department and cost center charges from 1991 through 1995. About $2.2 million related to department charges, including $1,377,036 for external relations, $717,760 for international relations, $34,082 for MetLife individual sales, and $25,667 for group strategic business and market management. The remaining $400,000 in charges related to specific cost centers, including, among others, management office-staff and corporate dining expenses. We were unable to determine that any of the cost center charges in question benefited the program.

Unallowable charitable contributions. We noted that MetLife charged FEGLI $95,836 for unallowable charitable contributions in 1991 and 1992. Such charges are in violation of federal regulations governing the program.

Interest on overpaid claims. The audit also showed that MetLife was not attempting to collect the interest portion of life insurance benefits paid in error to inappropriate recipients. Interest is paid on the amount of the life insurance coverage, or accidental death and dismemberment coverage, when the beneficiary is not paid within 30 days of the date of death of the insured to the date of payment up to a maximum of two years. MetLife focused its collection efforts on the principal amount of the benefit payments. According to the Federal Employees Group Life Insurance Federal Acquisition Regulations (LIFAR), interest paid as a result of delayed claim payments is part of the claims costs. The regulations also provide that, when benefits are paid in error, the contractor is to make a diligent effort to recover the erroneous payment from the recipient. MetLife has changed its procedures and now attempts to collect the interest portion of claims paid in error.

Lost Investment Income

In accordance with LIFAR, MetLife is required to pay OPM investment income that would

have been earned had the inappropriate charges not been made. As a result of the audit findings presented in the audit report, we determined that the FEGLI program was due $204,026 for lost investment income.

Internal Controls

We determined that the internal controls procedures that MetLife had in place to ensure that unallowable and/or unallocable expenses were excluded from the administrative expenses charged to the FEGLI program were not adequate during the years covered by the audit. As a result of our audit, MetLife told us that, effective October 1, 1996, procedures had been implemented to ensure that inappropriate costs are not charged to FEGLI in the future.

MetLife Commits to Improved Internal Controls

OTHER EXTERNAL AUDITS

As requested by Office of Personnel Management procurement officials, our OIG conducts pre- and post-award contract audits relating to the acquisition of goods and services by agency program offices. Our office also conducts audits of the local organizations of the Combined Federal Campaign (CFC), the solely authorized fund-raising drive conducted in federal installations throughout the world .

Pre-Award and Post-Award Contracts

These contract audits are performed to ensure that costs anticipated to be, or claimed to have been, incurred under the terms of these contracts are accurate and in accordance with provisions of the Federal Acquisition Regulation. The results of these audits provide OPM procurement officials with the best information available for use in contract negotiations and oversight. In the case of post-award contracts, for instance, the verification of actual costs and performance charges may be useful in negotiating contract modifications as these relate to cost-savings and efficiency.

We did not conduct any external contract audits in this area during the reporting period.

Combined Federal Campaign

On March 18, 1961, Executive Order 10927 transferred to the chairman of the U.S. Civil Service Commission (the precursor of OPM) the responsibility to arrange for national voluntary health and welfare agencies to solicit funds from federal employees and members of the armed services at their place of employment. Since then, there have been two more executive orders, one public law (P.L. 100-202), and the issuance of federal regulations (5 CFR 950) detailing the eligibility of national and local organizations and charities as CFC participants, the role of local CFCs, and the oversight responsibilities of the Office of Personnel Management relating to the Combined Federal Campaign.

Our oversight responsibilities include auditing the local CFCs and reviewing audits performed by independent certified public accountants (CPAs). Our audits focus on the eligibility of local charities participating in the campaigns, local campaign compliance with CFC regulations, and the testing of the various local campaigns' financial records. CFC audits will not ordinarily identify savings to the government, because the funds involved are charitable donations made by federal employees.

Our agency requires annual audits be performed by independent CPAs for large campaigns with total gross receipts of over $250,000. These CPAs are required to offer an opinion on both compliance with regulations and the financial activities of these campaigns. To assist local CFCs with these audits, OPM provides them written audit guidance.

For local campaigns with total gross receipts of $250,000 or less, OPM does not require an audit, but the campaigns must complete a compliance assessment provided by OPM. For organizational purposes, each local campaign must have an organization, usually a local charity, called the Principal Combined Fund Organization (PCFO). This entity is responsible for training employee keyworkers and volunteers; preparing pledge cards and brochures; distributing campaign receipts; responding in a timely and appropriate manner to all inquiries from participating organizations, OPM's Director, etc.; and consulting with federated groups on the operations of the local campaign. While audits of these campaigns are not required, each PCFO's overall organization must still be audited annually and maintain all organization and campaign financial records in accordance with generally accepted accounting principles.

Since 1961, the CFC has netted over $3.4 billion in charitable contributions. Approximately 391 local campaigns participated in the 1996 CFC, the most recent year for which statistical data was available. Federal employee contributions reached $193.6 million for the 1996 CFC, while expenses totaled $15 million.

During the current reporting period, we issued two CFC reports, a listing of which can be found in Appendix V on page 60 of this report.

OPM INTERNAL ACTIVITIES AUDITS

Our office also has responsibility for conducting a wide range of audit activity covering OPM programs and administrative operations. This activity includes such diverse areas as financial statement audits required by the Chief Financial Officers Act (CFO Act); President's Council on Integrity and Efficiency government-wide audits; audits of agency compliance with laws and regulations, such as the Prompt Payment Act, the Federal Managers' Financial Integrity Act (FMFIA), the Federal Financial Management Improvement Act (FFMIA); and performance audits of OPM programs that involve the range of the agency's responsibilities for retirement, employee development, and personnel management activities.

We have established a one-to-five-year optimum audit cycle for each of the aforementioned audit areas, depending upon the existence of legal requirements to conduct audits and the materiality and other risk factors associated with each activity.

Due to resource limitations, we have eliminated all internal agency audits from our agenda with the exception of OPM's financial statements audits. As a consequence, our office did not issue any audit reports concerning OPM programs and administrative activities during this reporting period. However, our Office of Evaluation and Inspections continues to perform evaluations of agency program and administrative activities. For a summary of those activities, please refer to the Evaluation and Inspections Activities section of this report on pages 45-51.

Agency Financial Statements Audits

The fiscal year 1997 CFO Act audits of OPM's benefits programs financial statements were performed under contract by an independent public accounting firm (IPA), KPMG Peat Marwick LLP (KPMG). These audits covered financial statements related to OPM's retirement, health, and life insurance benefits programs. Our office monitored these financial statement audits to ensure that the IPA performed all work in accordance with the contract and in compliance with government auditing standards and other authoritative references pertaining to OPM's financial statements. Our oversight of the IPA's work and review of the work papers and reports provided sufficient evidence for us to concur with the IPA's opinions. A summary of the reports issued by the IPA appears in this section.

Additionally, OIG auditors attempted to perform audits of OPM's revolving fund (RF) and salaries and expenses accounts (S&E) FY 1997 financial statements. However, due to limitations on our scope of work resulting from incomplete agency record keeping, among other problems, we concluded that we would be unable to express an opinion on the fairness of the financial statements. We have provided an audit narrative summarizing our report on this work.

We also released an audit report during the reporting period pertaining to internal controls and related management issues associated with OPM's FY 1996 RF and S&E financial statements. A summary of that report is also described in this section.

Office of Personnel Management's Fiscal Year 1997 Benefits Programs Financial Statements

Report No. 2F-00-97-105

February 27, 1998

Under provisions of the CFO Act, our office is required to audit and report on the financial statements of OPM's reporting entities or select an independent accounting firm to do so. Under a contract monitored by our office, the international accounting firm of KPMG Peat Marwick LLP performed audits of OPM's fiscal year 1997 benefits programs financial statements.

As mentioned on the preceding page of this report, the benefits programs financial statements reviewed during this audit covered the retirement, health, and life insurance programs. These benefit programs are key to the uninterrupted flow of benefits to federal civilian employees, annuitants, and their respective dependents, and operate under the following names: the Civil Service Retirement System (CSRS), the Federal Employees' Retirement System, the Federal Employees Health Benefits Program, and the Federal Employees' Group Life Insurance program, all administered by OPM's Retirement and Insurance Service.

KPMG's fiscal year 1997 audit report includes opinions on the benefits programs financial statements, as well as reports on internal controls and the agency's compliance with laws and regulations pertaining to these programs. Table 1 on page 29 includes reportable conditions that KPMG identified during their audit work on the financial statements and reportable conditions that they consider to be material weaknesses in the internal controls. A summary of KPMG's audit work is reflected below.

Retirement Benefits Program

Retirement program. KPMG issued an unqualified opinion on the retirement program (RP) financial statements. Improvements in the RP control environment during fiscal year 1997 were recognized through the reduction of several material weaknesses to reportable conditions. However, in its accompanying report on internal controls, KPMG identified material weaknesses in the following areas:

- Controls over contributions revenue.
- Cash management related to investments.
- System development life cycle for major systems implementation efforts.
- Financial reporting, policies and procedures.

In addition, KPMG identified reportable issues related to certain laws and regulations. Issues reported included instances where the RP was not in substantial compliance with federal system requirements and the U.S. Standard General Ledger (SGL), both of which have been incorporated in the Federal Financial Management Improvement Act (FFMIA). KPMG auditors also found one additional material weakness in their evaluation of the RP's internal controls than OPM noted in its FMFIA report.

Health Benefits Program

Health benefits program. KPMG issued a disclaimer of opinion on the health benefits program (HBP) FY 1997 financial statements, commenting that OPM does not have an adequate control system over carrier-reported activities and that adequate evidential matter was unavailable to support transactions and balances related to insurance premiums and activity of all carriers.

The HBP continues to make improvements in its internal controls environment, and several material weaknesses were reduced to reportable conditions during fiscal year 1997. However, in its accompanying report on internal controls, KPMG identified material weaknesses in the following areas:

- Controls over contributions revenue.
- Cash management related to investments.
- System development life cycle for major systems implementation efforts.
- Financial reporting, policies and procedures.
- Controls over insurance premiums.

As was the case in the preceding retirement benefits program section of the report, KPMG identified reportable issues related to certain laws and regulations. KPMG auditors noted instances where the HBP did not substantially comply with federal system requirements, the SGL, or federal accounting requirements, all of which are now incorporated in the FFMIA. The auditors at KPMG also determined in their evaluation of the HBP's internal controls that an additional material weakness existed that OPM did not include in its FMFIA report.

Life Insurance Benefits Program

Life insurance program. KPMG issued an unqualified opinion on the life insurance program (LP) financial statements. Improvements in the LP control environment during FY 1997 were recognized through the reduction of several material weaknesses to reportable conditions. However, in its internal controls report, KPMG listed material weaknesses in the following four areas:

- Controls over contributions revenue.
- Cash management-investments.
- System development life cycle for major systems implementation efforts.
- Financial reporting, policies and procedures.

KPMG also identified reportable issues related to certain laws and regulations. There were instances of substantial noncompliance in the LP involving both federal system requirements and the SGL (now incorporated in the FFMIA). As was the case with both the RP and HBP, OPM identified one fewer material weakness in its FMFIA report than did the KPMG auditors during their evaluation of the LP's internal controls.

OIG Monitors IPA Benefits Programs Financial Statements Audits

Table 1.

Fiscal Year 1997 Internal Control Weaknesses			
Issues	***Retirement Program***	***Health Insurance Program***	***Life Insurance Program***
Controls Over Contributions Revenue	M	M	M
Cash Management - Investments	M	M	M
System Development Life Cycle for Major Systems Implementation Efforts	M*	M*	M*
Financial Reporting, Policies and Procedures	M	M	M
Controls Over System Software	RC	RC	RC
Comprehensive Computer System and Application Risk Assessments	RC	RC	RC
Controls Over Benefit Payments Made to Annuitants	RC	N/A	N/A
Controls Over Insurance Premiums	N/A	M	N/A
Reconciliation of Inter-Program Transactions	N/A	RC	RC
Review Procedures Over Carrier Benefit Payments	N/A	N/A	RC

M = ***A reportable internal control weakness considered to be a material weakness***
M* = ***A material weakness in internal control that was not included or properly reported in OPM's FMFIA report for the year in question***
RC = ***A reportable condition***
N/A = ***Not applicable***

Report on Office of Personnel Management's Fiscal Year 1997 Revolving Fund and Salaries and Expenses Accounts Financial Statements

Report No. 2F-00-97-102

March 2, 1998

Our work this period included the second attempt at full-scope audits of the revolving fund and salaries and expenses accounts financial statements. Due to continuing significant limitations on the scope of our work, we were unable to express an opinion on the FY 1997 financial statements, as was the case with the FY 1996 financial statements. These scope limitations were due mainly to the inability of the Office of the Chief Financial Officer (OCFO) to provide standard accounting records for substantially all of the material accounts and line items represented in the statements.

Section 5(b) of the FFMIA requires Inspectors General to report information to Congress related to the agency's compliance with this Act. Our report of disclaimer on the FY 1997 revolving fund and salaries and expenses accounts details our conclusions regarding the agency's compliance with the FFMIA. In summary, we reported instances where the RF and S&E financial management systems did not substantially comply with federal financial management system requirements, applicable accounting standards or the standard general ledger.

Our reports of disclaimer also identified the following material internal control weaknesses:

Revolving Fund Financial Statements

Revolving fund. We identified several material internal control weaknesses during our audit of the RF financial statements. These included the following:

- Operating policies and procedures either not current or not documented for substantially all accounts and line items or for financial statement preparation.
- Year-end adjustments to account balances totaling $93 million for the purpose of preparing the financial statements not recorded in the general ledger.
- Poor cash reconciliation procedures over the past few years resulting in unreconciled differences of approximately $19 million between the RF cash general ledger balances and U.S. Treasury records, such as the TFS 6653 - Undisbursed Appropriation Account Ledger.
- Accounts receivable aging schedules not prepared on a regular basis, and past due notices not sent to debtors during FY 1997.
- Inadequate controls over transactions entered into the general ledger. Examples included insufficient supervisory review of transactions and no evidence of periodic analytical reviews of transactions and balances in the general ledger. These affected substantially all areas reviewed, including property and equipment, accounts payable, and transactions with US Investigations Services, Inc. (USIS), a private-sector contractor. As a result, trial balance amounts were not consistent with the SGL. All of the preceding led to a delay in the preparation of the RF financial statements.

S&E Accounts Financial Statements

Salaries and expenses accounts. We also identified several material internal control weaknesses during our audit of the S&E financial statements. These are listed below and are almost identical to those control weaknesses associated with the revolving fund.

- Operating policies and procedures either not current or not documented for substantially all accounts and line items or financial statement preparation.
- Year-end adjustments to account balances totaling $65 million for the purpose of preparing the financial statements not recorded in the general ledger.

- Poor cash reconciliation procedures resulted in unreconciled differences of approximately $37.6 million between the S&E cash general ledger balances and U.S. Treasury records, such as the TFS 6653 - Undisbursed Appropriation Account Ledger.
- Accounts receivable aging schedules not prepared on a regular basis and past due notices not sent to debtors during FY 1997.
- Controls over transactions entered into the general ledger not adequate. Insufficiencies included infrequent supervisory review of transactions and no evidence of periodic analytical reviews of transactions and balances in the general ledger. These control problems affected substantially all areas we reviewed, including property and equipment and accounts payable. Also, trial balance amounts were inconsistent with the SGL. These factors all contributed to a delay in the preparation of the S&E financial statements.

OIG Issues Disclaimer of Opinion on FY 1997 RF & S&E Financial Statements

Table 2 below provides a complete list of the areas in which we identified material weaknesses for the RF and S&E Accounts for FY 1997. As can be seen from the table, OPM reported all of these weaknesses in its FY 1997 FMFIA report, including the three not included in the agency's FY 1996 report.

Table 2.

Fiscal Year 1997 Internal Control Weaknesses		
Issues	***Revolving Fund***	***Salaries & Expenses Accounts***
Operating Policies and Procedures	M	M
Financial Statement Preparation	M	M
Fund Balances With Treasury	M	M
Accounts Receivable	M	M
Property and Equipment	M	M
Accounts Payable	M	M
USIS Transactions and Balances	M	N/A
Controls Over Recorded Transactions	M	M

M = ***A reportable internal control weakness considered to be a material weakness***
M* = ***A material weakness in internal control that was not included or properly reported in OPM's FMFIA report for the year in question***
RC = ***A reportable condition***
N/A = ***Not applicable***

Report on Internal Control and Related Management Issues From the Audits and Related Work on the Office of Personnel Management's Fiscal Year 1996 Revolving Fund and Salaries and Expenses Accounts Financial Statements

Report No. 2F-00-97-101

November 3, 1997

This report was based upon the audit work that our office performed during the fiscal year 1996 audits of OPM's RF and S&E financial statements, and contains additional detail on significant internal control weaknesses and other issues. Our reports and disclaimers of opinion on the RF and S&E FY 1996 financial statements were issued on July 2, 1997, and summarized in our semiannual report issued last fall.

RF and S&E Accounts Internal Controls and Compliance with Laws and Regulations

As a result of our audit work, we identified areas that represent material weaknesses in internal controls. For each weakness, we provided OPM management with specific recommendations for improvement. Each of the areas contains elements that are reportable as material weaknesses under the requirements of the FMFIA.

Given the severity of the material weaknesses we reported in fiscal year 1996, OPM was unable to correct them prior to the completion of fiscal year 1997. Consequently, all of the weaknesses were again noted during our FY 1997 audit, previously described on pages 29-31. Table 3 on the following page includes material weaknesses we identified during our audit work. Material weaknesses not reported in OPM's FY 1996 FMFIA report are noted with an asterisk.

In addition, we reported that the agency was not in compliance with FMFIA, because OPM management did not include three material weaknesses and one nonconformance in OPM's 1996 FMFIA report. The weaknesses included financial statement preparation, property and equipment, and transactions with USIS. We also determined that there was nonconformance with OMB Circular A-127, Financial Management Systems, due to the fact that the property and equipment subsystem was not integrated with the general ledger.

Table 3.

Fiscal Year 1996 Internal Control Weaknesses		
Issues	***Revolving Fund***	***Salaries & Expenses Accounts***
Operating Policies and Procedures and Systems Integration	M	M
Financial Statement Preparation	M*	M*
Fund Balances With Treasury	M	M
Accounts Receivable	M	M
Property and Equipment	M*	M*
Accounts Payable	M	
USIS Transactions and Balances	M*	N/A

M = ***A reportable internal control weakness considered to be a material weakness***
M* = ***A material weakness in internal control that was not included or properly reported in OPM's FMFIA report for the year in question***
RC = ***A reportable condition***
N/A = ***Not applicable***

Health Insurance Carrier Financial Accountability

Our office and the agency's Retirement and Insurance Service are continuing efforts to bring about better financial accountability and increased oversight to the FEHBP. In an article appearing in last fall's semiannual report, we made reference to an Experience-Rated Health Insurance Carrier Quality Improvement Team (ERCQIT) our OIG and RIS had formed in 1995 to ensure that these particular FEHBP-participating insurance carriers met federal government financial reporting and audit requirements. The lack of adequate oversight and control over experienced-rated carrier-reported amounts and balances used for financial statement reporting is a material weakness that contributed to a disclaimer of opinion on the FEHBP's FY 1996 and FY 1997 financial statements. In addition to OPM and OIG representatives, the ERCQIT included health insurance carriers and their independent public accountants. As we also reported last fall, the ERCQIT developed several recommendations to improve controls and accountability. This activity took place in September 1996, with the most critical recommendation calling for the development of an audit guide for carriers that would provide for improved controls over carrier-processed activity.

In December 1997, the ERCQIT issued a final draft audit guide to carriers. Based on carrier comments, OPM management has decided to revise and reissue the guide this May. The audit guide describes expanded reporting requirements for carriers and audit procedures to be conducted on carriers' FEHBP operations by their IPAs beginning in FY 1998. We believe these procedures are critical steps in eliminating the disclaimer of opinion on the FEHBP financial statements.

Further, the audit guide provides the OIG with new opportunities to expand the scope of our work in the highly vulnerable health insurance area. As was mentioned in the Message From the IG section in our last report, the infrequency of audits of FEHBP insurance carriers has been reported as an agency material weakness under FMFIA. The IPA work related to assessing internal controls will help eliminate this weakness and target carrier program operations where the internal controls are weak. By combining the work of the IPAs with our own work, we will be able to expand the level of oversight of FEHBP carrier operations significantly.

Agency Efforts to Improve Carrier Accountability Continue

OIG Assists OCFO Efforts to Improve Internal Controls

As noted in the audit narrative regarding OPM's revolving fund and salaries and expenses accounts, for the last two years our audits of these two administrative accounts have resulted in disclaimers of opinion on both the RF and S&E financial statements. In an effort to effect program-wide controls, the OCFO requested assistance from our office after the FY 1996 audits in correcting the identified material weaknesses. Accordingly, we detailed one of the OIG's senior managers from the Office of Audits to the OCFO to assist in their efforts to improve the internal control structure and increase the reliance users could put on data produced within that control structure.

In addition, the OIG is participating in a transaction code quality improvement team with the OCFO, the objective being to identify and correct transaction codes that are defined incorrectly and are resulting in erroneous entries to the general ledger. This problem contributed to the incorrect balances in the general ledger that delayed the preparation of the RF and S&E FY 1997 financial statements until February 1998. The OIG is also working with the OCFO to develop reconciliations between the general ledger and supporting detail for investigations transactions with USIS, which represented $106 million of the RF's revenue in FY 1997. Other quality improvement teams will cover a variety of critical areas and provide the OCFO and our office an opportunity to improve controls in an efficient and effective manner.

OIG Teams With OCFO to Improve Internal Controls

OIG Uses Automated Workpaper Software

During the FY 1997 financial statement audits of the RF and S&E, our OIG used an automated workpaper system to document all audit work performed. This change in approach for documenting our work is part of a continuing effort to perform our work more efficiently, while meeting all generally accepted government auditing standards work-paper requirements. The process of moving to automated working papers began with an OIG team surveying the audit software available on the market, comparing the capabilities of several options, and selecting one package to test for a complete audit cycle. The audit team attended training sessions for the software. It was implemented at the beginning of the planning phase of the financial statement audits.

Automated working papers will clearly be standard in the not-too-distant future. This is evidenced in a guide recently published by the Federal Audit Executive Council's Committee on Auditing in a Paperless Environment, entitled "Automating the Audit Work Paper Process." One of our OIG auditors served on this committee and helped develop the guide. Benefits to be realized through such automation include much more efficient storage and maintenance of workpapers, a significant reduction in the amount of hard copies produced, the ability to view the status of audit work by component or in total at any time, and more efficient report preparation.

OIG Assists in Developing Paperless Workpaper Auditing Guide

Investigative Activities

The Office of Personnel Management administers benefits from its trust funds for all federal civilian employees and annuitants participating in the federal government's retirement, health and life insurance programs. These trust fund programs cover approximately 9.5 million current and retired federal civilian employees, along with their family members, and disburse about $60 billion annually. The investigation of fraud involving OPM's trust funds occupies the majority of our OIG investigative efforts.

During this reporting period, we have continued to aggressively pursue criminal and civil sanctions against both individuals and corporate entities. These efforts have produced 10 arrests and 12 convictions. More importantly, however, they have resulted in judicial and administrative monetary recoveries to the OPM-administered trust funds totaling $921,119. Other investigative efforts resulted in the detection of two ongoing frauds in the Civil Service Retirement System, with a projected savings of $88,500 to the Civil Service Retirement and Disability trust fund over the next five years. Overall, we opened 32 investigations and closed 22 during this reporting period, with 117 still in progress at the end of the period. (See Table 1 for investigative activity highlights on page 43 of this section.)

Calls received on our retirement and special investigations hotline and our health care fraud hotline, along with complaints mailed in, totaled 1,093. Additional information, including specific activity breakdowns for each hotline, can be found on pages 41-42 in this section.

In keeping with the emphasis that Congress and various departments and agencies in the executive branch have placed on combating health care fraud, we have increased our efforts to communicate and coordinate our investigations with the Department of Justice (DOJ) and other federal, state, and local law enforcement agencies. At the national level, we are participating members of DOJ’s health-care fraud working group. We recently joined the U.S. Attorney’s offices in their efforts to further consolidate and increase the focus of investigative resources in those regions that have been particularly vulnerable to fraudulent schemes and practices engaged in by unscrupulous health care providers.

In the retirement area, we have continued our proactive efforts to identify fraud by routinely reviewing CSRS annuity records for indications of unusual circumstances, as well as maintaining contact with the federal annuitant population. While our recoveries in this area are, for the most part, smaller than in the health care fraud area, criminal prosecutions and sentences tend to be more significant.

On the following pages, we have provided narratives relating to health care and retirement fund fraud and abuse cases we worked and closed during the reporting period.

Retirement Fraud and Special Investigations

In accordance with our mission to prevent and detect fraud, OIG special agents routinely review CSRS annuity records for indications of unusual circumstances. Using excessive annuitant age as an indication of potential fraud, our investigators attempt to contact the annuitants and determine if they are alive and still receiving their benefits. In addition, we receive inquiries from OPM program offices, other federal agencies and private citizens that prompt us to investigate cases of potential retirement fraud or alleged misconduct by OPM employees and contractors.

Cited below are narratives related to two of the cases in these areas that we completed during this reporting period.

Family Member Identified in Annuity Fraud

As a result of information OPM received from a family member, our office conducted an investigation of CSRS benefits paid to an annuitant who died in December 1991. Because the death had not been reported to OPM, annuity payments totaling approximately $90,790 were erroneously dispersed after the annuitant's death.

Our OIG investigators went to the deceased annuitant's address to deliver forms for the spouse's survivor annuity. They previously had been told by the daughter that the spouse was alive and awaiting the forms. The deceased annuitant's daughter answered the door but did not reveal her identity. She stated that the annuitant's spouse had died, that the daughter was out of town at the moment, but would be making restitution.

As a result of our investigation, we learned that the annuitant's spouse and daughter had negotiated the annuity payments issued to the annuitant after his death. Some of the checks were forged and cashed, while others were negotiated through a joint account used by the mother and daughter. As the investigation proceeded, our investigators were able to determine that the daughter had concealed her identity intentionally the first time she talked to them in an effort to hide her involvement in the fraud.

Our investigators obtained a warrant and arrested the annuitant's daughter. While originally indicted on 1 count of conspiracy, 15 counts of mail fraud, 15 counts of conversion of government property, and 15 counts of forgery, the annuitant's daughter later pleaded guilty to violating one count of conspiracy. She was sentenced to six months in prison, with credit for seven days served. Upon release from prison, she will be on supervised release for a period of three years. She also must pay a special assessment fee of $50.

OPM was successful in recovering the total annuity overpayment by pursuing three avenues: Department of the Treasury reclamation action (wherein annuity check amounts can be retrieved directly from banks or individuals), the sale of the annuitant's property, and insurance policy proceeds due the annuitant's daughter.

Investigators Achieve $90,790 Recovery for U.S. Civil Service Retirement Fund

OPM Employee Admits to T&A Fraud

As a result of information received from OPM's Office of Human Resources Systems Service, our office initiated an investigation of an OPM employee suspected of being paid for overtime hours not worked. The employee, a secretary who served as a time and attendance (T&A) clerk, had the authority to enter her own T&A information. She had received over $8,000 in overtime compensation that her supervisor believed she did not earn.

An audit of the T&A sheets submitted by the employee determined that, between April 1995 and December 1996, she received pay for working approximately 525 hours of overtime. The employee was interviewed by our OIG agents and, in a written statement, admitted working no more than 24 hours of legitimate overtime.

The results of the investigation were discussed with the U.S. Attorney's office in the District of Columbia, which agreed to prosecute the employee. Prior to the initiation of judicial action, the employee was terminated from her position at OPM. The employee subsequently pleaded guilty to two counts of violating 18 U.S.C. § 641, theft of government funds. She was later sentenced to five years probation and ordered to make restitution to OPM in the amount of $8,367.

Fired OPM Employee Prosecuted and Ordered to Pay $8,367 Restitution.

Health Care-Related Fraud and Abuse

Our OIG special agents are in regular contact with the numerous insurance carriers participating in the FEHBP to provide an effective means for reporting instances of possible fraud by health care providers and FEHBP subscribers. Our office also maintains liaison with federal law enforcement agencies involved in health care fraud investigations and participates in several health care fraud working groups on both national and local levels. Additionally, we work closely with our own Office of Audits when fraud issues arise during the course of health carrier audits.

The following narratives describe four of the cases we concluded in the area of health care fraud during this reporting period.

Physician Involved in Billing Fraud

On January 20, 1998, the Department of Justice forwarded checks to three FEHBP insurance carriers totaling $265,318, resulting from the conviction of a Philadelphia, Pennsylvania physician involved in fraudulent billing practices.

The return of these funds was based on an order of forfeiture issued by the U.S. District Court in Philadelphia, Pennsylvania, following an investigation we conducted jointly with

the Federal Bureau of Investigation. The investigation disclosed that this physician had billed insurance companies, including FEHBP carriers, for services never rendered. He was convicted of mail fraud and money laundering and ordered to forfeit the sum of $2 million to the federal government. The portion returned to the FEHBP is represented by the amount received by the insurance carriers.

$265,318 Returned to FEHBP Carriers in Criminal Forfeiture

Provider Exposed in Non-Covered Service Billings

A four-year investigation conducted by our office in conjunction with the DOJ and other federal law enforcement agencies culminated in a civil settlement involving a physician from Arlington, Virginia, and the medical facility where he practiced that returned $240,944 to the federal government. Of this amount, the FEHBP received $200,000.

In addition to DOJ and our OIG, other agencies participating in this investigation were the Defense Criminal Investigative Service and the U.S. Postal Inspection Service. Case agents representing these law enforcement groups were involved in serving numerous grand jury subpoenas and reviewing voluminous health benefits claims records, the latter with the assistance of several FEHBP insurance carriers.

These agents determined that this physician and the medical facility submitted false claims for services to FEHBP carriers and CHAMPUS, the federal health benefits program serving active and retired military personnel and their families. The doctor billed carriers for covered services when, in fact, he was performing in-vitro fertilization and artificial insemination procedures, services specifically not covered under either the FEHBP or CHAMPUS.

FEHBP Receives $200,000 From Civil Settlement

Non-Physician PhD Engages in Deceptive Billing Practices

As a result of an investigation by our office, we determined that an individual with a doctorate degree in nutrition had conducted non-covered experimental therapy on patients and billed federal health insurance programs, including the FEHBP, CHAMPUS, and Medicare, for these treatments by disguising the therapy under what appeared to be medically necessary procedures.

In September 1997, this non-physician nutritionist pleaded guilty to making false claims to the government. On November 20, 1997, he was sentenced in U.S. District Court in Alexandria, Virginia, to six months of home detention and received three years probation. He also was ordered to make restitution in the amount of $555,000 to the federal government. As a result of the restitution order, the FEHBP received a total of $16,000, representing criminal and civil damages.

Non-Physician Convicted of Defrauding U.S. Government

Individual Submits False Medical Claims

An investigation conducted by our OIG and the U.S. Postal Inspection Service revealed that the spouse of a federal employee was reimbursed by an insurance carrier for medical expenses he claimed to have incurred while visiting the country of Cameroon. This individual fabricated the bills he submitted to the carrier and was never treated at the hospital. The investigation was carried out with the assistance of the hospital in Cameroon, the FEHBP carrier, and through executing a search warrant on a business operated by the subject.

Following his guilty plea to mail fraud in conjunction with submitting false claims for medical treatment to an FEHBP carrier, the spouse was sentenced in U.S. District Court in Charlotte, North Carolina, to five years probation and ordered to make restitution to the federal government in the amount of $11,400.

Fraudulent Overseas Medical Claims Scheme Uncovered

OIG Hotlines

The OIG maintains two hotlines, the Retirement and Special Investigations hotline and the Health Care Fraud hotline.

Retirement and Special Investigations Hotline

The Retirement and Special Investigations hotline provides the same assistance as traditional OIG hotlines. For example, we receive inquiries from OPM employees, contractors, and others interested in reporting waste, fraud and abuse within the agency. Callers, or those who choose to write letters, can report information openly, anonymously or confidentially without fear of reprisal.

The Retirement and Special Investigations hotline and complaint activity for this reporting period included 59 telephone calls, 55 letters, 25 agency referrals, 1 walk-in, and 86 complaints initiated by the OIG, for a total of 226. Our administrative monetary recoveries resulting from retirement and special investigation complaints totaled $58,165.

OIG-initiated complaints. Complaints initiated by our office can be one of two types. The first occurs when the agency has already received information indicating an overpayment to an annuitant has been made, and our review leads us to determine there are sufficient grounds to justify our involvement due to the potential for fraud. There were 17 such complaints associated with agency inquiries during this reporting period.

The second type of OIG-initiated complaint occurs when we review the agency's automated annuity records system for certain items that may indicate a potential for fraud. At

that point, we initiate personal contact with the annuitant to determine if further investigation is warranted. This proactive activity resulted in 69 instances where our office initiated personal contacts to verify the status of the annuitant.

Health Care Fraud Hotline

The Health Care Fraud hotline was established to handle complaints from subscribers in the Federal Employees Health Benefits Program administered by OPM. The hotline number is listed in the brochures for all the plans associated with the FEHBP.

While the hotline is designed to provide an avenue to report fraud by subscribers, health care providers or FEHBP carriers, frequently callers have requested assistance with disputed claims and services disallowed by the carriers. Each caller receives a follow-up call or letter from either the OIG hotline coordinator, the insurance carrier or another OPM office as appropriate.

The Health Care Fraud hotline and complaint activity for the period involved 644 telephone calls and 223 letters, for a total of 867. During this period, the administrative monetary recoveries pertaining to health care fraud complaints totaled $21,713.

Investigative Activity Tables

TABLE 1: Investigative Highlights

Judicial Actions:

Arrests	10
Indictments	5
Convictions	12
Administrative Actions	0
Judicial Recoveries:	
Fines, Penalties, Restitutions and Settlements	$ 841,241
Administrative Recoveries:	
Settlements and Restitutions	$ 79,878
Total Funds Recovered	**$921,119**

[1]*Includes suspensions, reprimands, demotions, resignations, removals, and reassignments.*

TABLE 2: Hotline Calls and Complaint Activity

Retirement and Special Investigations Hotline and Complaint Activity:	
Retained for Investigation	154
Referred to:	
OIG Office of Audits	0
OPM Groups and Offices	42
Other Federal Agencies	30
Total	**226**
Health Care Fraud Hotline and Complaint Activity:	
Retained for Investigation	207
Referred to:	
OPM Groups and Offices	266
Other Federal/State Agencies	97
Health Insurance Carriers or Providers	297
Total	**867**
Total Contacts	**1093**

Evaluation and Inspections Activities

Section 4(a)(3) of the Inspector General Act provides a broad mandate to IGs to assist their respective departments and agencies in promoting economy and efficiency and in preventing and detecting fraud and abuse with respect to their programs and operations. It calls for IGs to be proactive in their activities beyond those specifically prescribed under its audit and investigation responsibilities to make sure the intent and purposes of the Act are met.

Within this context, evaluation and inspections activities have become a core function within our OIG. Through these activities, we are providing assistance to agency program managers in an effort to determine the feasibility of new initiatives and the effectiveness and efficiency of existing operational methodologies. We conduct independent analytical reviews that often serve as the cornerstone for strategies to improve the delivery of services throughout the agency.

OPM has been in the forefront of the Administration's efforts to improve the quality of its services and reduce the size of government. Its program offices have experienced reorganizations, staff reductions, and new program mandates during the last few years, with the intended goal of becoming a "model agency" for the twenty-first century. Our office provides this agency with a unique tool to address a variety of the pressing issues associated with today's government reorganizing. The evaluative process we employ, whether requested by our agency's program offices or initiated from within the OIG, focuses on current issues, such as reduced funding, increased workloads, decreasing staffing levels, inefficient or ineffective services, private or public-sector inquiries concerning delivery of services, and the absence of objective evaluative data to use in determining the impact of programs.

We are now working with agency program offices to identify ways to improve services, increase accountability, and minimize resource demands. Currently, our staff is continuing to conduct its scheduled reviews of common services delivery within the administrative areas of the agency's Office of Contracting and Administrative Services (OCAS), as described in our last semiannual report.

The purpose for performing these specific evaluations is to determine whether decreased funding and the resulting staff reductions within these offices have had a dramatic impact on their respective servicing abilities in supporting the redefined core functions of OPM. While the services provided by administrative functions are not highly visible outside the agency, the ability of OPM program offices to achieve the primary objectives of the agency are nevertheless closely associated with these internal operations.

In our semiannual report issued last fall, we stated that our office had completed the second in a series of OCAS administrative reviews of OPM's common services. We did not include summaries of those reviews at that time, because OCAS management had requested additional time to review the final report before providing comments on our findings and recommendations. OCAS's comments have now been received.

This review covered three distinct administrative areas. Two of these, the OPM resource center, which replaced the agency's full-service library in 1995, and the agency's mail management operations, are assigned to the publishing services division (PSD). The third administrative area highlighted in this report covers procurement and contracting services performed by OPM's contracting services division (CSD).

In addition to our staff's ongoing efforts in conducting agency program evaluations during this reporting period, we also performed oversight activities related to OPM's implementation of the Government Performance and Results Act (GPRA). Significant time and effort were devoted to conducting assessments of annual performance plans of various agency components to determine their compliance with GPRA.

The following summaries of the above-referenced OCAS administrative support service reviews, as well as the oversight activities we conducted to facilitate OPM's implementation of GPRA-compliance initiatives, include some of our major findings and recommendations.

OIG Continues Agency Program Reviews

OCAS Service Delivery Reviews

During fiscal year 1995, OPM announced various changes in its organizational structure that altered agency requirements for administrative services. As previously stated, our OCAS study was initiated to determine if resulting reductions in staff and decreased funding for these support services were having or would have an adverse impact on these services to agency customer groups and organizations, and whether these services were being maintained at acceptable levels of efficiency and effectiveness.

Resource Center

The former library, designated a federal depository library, was considered the federal government's primary source of information on personnel matters, with a customer base of not only internal and external federal employees, but both public and private-sector groups, entities, and individuals. It was restructured as a resource center on August 29, 1995, to coincide with OPM's downsizing initiatives, opening for business on October 1 of that same year. As a consequence, the library's holdings decreased from over 120,000 volumes to approximately 11,000 volumes.

Dispersal of OPM library collection. As a result of this agency's library restructuring initiative, what remains of OPM's library collection is primarily a legal reference library, with a limited number of regulatory and other historical personnel management resource materials and publications deemed essential to our agency's core functions.

During the course of our research, we found that the dispersal of the OPM library collection was poorly handled. The library's unparalleled collection of human resources material was distributed both to OPM program offices or various universities. Other material went to the Library of Congress and the National Archives. Agency program

office staff were also invited to take any library materials they needed, with the understanding that they would provide the resource center staff with a list of the materials removed. Unfortunately, the effort to provide these lists was inconsistent, so that an accurate record of most of the items removed is not available.

In 1996, OCAS management purchased an automated system for the resource center to provide more efficient management of material in the resource center collection, including acquisition, cataloging and circulation. However, since the shelf-list and public access card catalogs were destroyed during the downsizing process, most of the information in this automated system remains incomplete. Additionally, the partial inventories provided by program offices have not yet been put into the computerized system. Other important material, such as legislative histories and archival material on the history of the U.S. Civil Service Commission, also is not referenced in the system.

Resource materials vulnerability. The current staffing situation has contributed directly to the problem with inventory controls, which range from weak to nonexistent. In addition, there is no physical security system to safeguard these resource materials, thereby leaving the collection vulnerable to theft when the resource center is unattended. We believe that the collection's vulnerability is a product of reduced funding levels and staffing cuts that occurred at the beginning of FY 1996. For instance, in late 1995, the resource center staffing levels were reduced from four to two, the same level that remains today. It is noteworthy that one of these employees is available to the resource center only a part of each week, since that individual has other work responsibilities in another office as well. This situation, of course, compromises full-time coverage of the resource center. OCAS management has agreed to assign other staff to ensure a physical presence when resource center staff members are not available.

Unrecovered on-line service dollars. The resource center currently subscribes to two on-line computer services through an interagency agreement with the Library of Congress. This agreement calls for advanced payment on a fiscal-year basis. When incurred costs are less than the funds obligated in the agreement, the user agency may specifically request a refund of service dollars from its existing account. However, should the Library of Congress not receive such a request prior to the end of the fiscal year, the funds are lost for reobligation, since federal law prohibits carrying these funds over to the next fiscal year.

During our review, we noted that OCAS had failed to make timely refund requests for the unused portions of funds dedicated to these on-line services for fiscal years 1992 through 1996, thereby losing the opportunity to put these funds to better use. The amount totaled more than $9,600. In 1997, OCAS did reduce the amount of each subscription, but this amount still exceeds expected usage. Assuming that the deposit account amounts and usage for these on-line services remain at FY 1997 levels, we calculated that timely refund requests over the next five years could result in a cost avoidance of approximately $9,000 to the agency. OPM agreed with this recommendation. (See also Appendix II on page 56.)

Need for Improved On-Line Resource Center Services and Oversight Identified

Mail Management

With the downsizing of OPM, other changes occurred affecting the agency's mail management operations in the mail management branch (MMB). For instance, the contract for daily pickup and delivery of mail between primary field locations and the central office was eliminated, as was the branch's role as a coordinator for these services with the U.S. Postal Service and various courier services. As a result, each agency program office has been required to assume this responsibility independently.

Inadequate mail processing training. In 1996, the agency implemented a dramatic change in its mail processing operations by switching to the current industry standard of computer-based technology to replace its manually operated equipment. We discovered that, although current technology has been introduced in MMB's day-to-day operations, some of the mailroom staff has not been provided the training necessary to perform efficiently in this new environment. This represents an impediment to maintaining efficient customer service.

Misassignment of GSA-leased vehicles. For several years, MMB has been responsible for four General Services Administration (GSA)-leased vehicles used in providing mail pickup and deliver services, transferring property, and transporting agency staff to various official events. We evaluated the use of these four vehicles to determine if their current uses met the requirements established when the leasing was first approved.

We found that MMB's use of these vehicles had decreased commensurate with the loss of staff and duties due to agency downsizing. We also noted that other agency program offices had been using some of these vehicles for their own authorized use on an ongoing basis, yet all four vehicles remained under MMB's base budget. As a result of our recommendation, OCAS reassessed its need for these vehicles and determined that MMB would retain two vehicles, one passenger van and one 2-ton truck, but terminate the lease on one 15-passenger van, resulting in a savings of $2,920 a year to the agency. OCAS gave the RIS program offices that had been using the other passenger van the option of having it assigned to RIS, which has now occurred. (See also Appendix II on page 56.)

Delivery of services and delayed payments. Another significant issue concerning mail management operations was the processing of shipping invoices. We discovered that frequent problems existed in the preparation of requests for commercial mail shipping services, along with the manner in which invoices for these services were processed and paid.

Procedures require that, regardless of carrier or type of shipping request, all request forms not only must be completed by the requesting program office but also must contain accurate accounting information to ensure efficient processing for payment by the agency's Office of the Chief Financial Officer. If the forms are incomplete when received in MMB, the branch chief must expend an inordinate amount of time searching for and recording the correct information before these can be sent to the OCFO for payment. We discovered

that, on average, the time to process a payment for an invoice that required corrections by MMB could take as long as 12 weeks, rather than the normal processing time of 7 to 10 days.

We made nine recommendations in our final report regarding the agency's mail management operations. Areas of concern not already mentioned include outdated position descriptions, employee training, and guidance on commercial mailing and shipping procedures.

Contracting Services

Also, as part of the agency's downsizing efforts, all remaining contracting services division staff were reclassified as contract specialists through instituting cross-training activities to ensure that each employee could effectively perform both procurement and contract functions. An aggressive training program was likewise initiated throughout the agency to allow program personnel to obtain the necessary warrants to execute procurement actions with a ceiling of $100,000. By eliminating the need for written terms and conditions and raising the ceiling of small purchases from $1,000 to $2,500, the Federal Acquisition Streamlining Act of 1994 allowed for a level of delegation of authority that would otherwise have been much more difficult to achieve and maintain.

In recognition of the authorities cited in this Act, numerous agency employees have been authorized to use government credit cards under the International Merchant Purchase Authorization Card (IMPAC) program. The IMPAC card allows for single purchases of up to $2,500.

Unnecessary assignment of credit cards. In any given month, approximately 120 out of the 170 IMPAC cards currently assigned to agency personnel are actually used to procure items. Having more cards issued than absolutely necessary places the agency at some financial risk, even if most cards are limited to a single purchase limit of $2,500. For instance, purchases on a lost or stolen card limited to such amounts are much less likely to be noticed immediately, leaving the agency vulnerable to multiple misappropriation of funds over a period of time.

Inaccurate vendor lists and prompt payment issues. Another concern regarding CSD operations is the process of maintaining accurate lists of those vendors with whom OPM deals. The Debt Collection Improvement Act of 1996 requires that all payments to vendors be made by electronic funds transfer unless the vendor can demonstrate that this is not possible. To implement this requirement, government procurement officials must obtain very specific banking account information from prospective vendors so that appropriate and accurate transfers can be executed.

We found that some vendors are unfamiliar with this regulation and are at times reticent to provide the required information. In addition, we discovered that there is no standardized agency form for vendors to use, and that such a form should provide the specific citation relating to this regulation [3 CFR 3332 (a) through (d), as amended by the Debt Collection Improvement Act of 1996]. Vendor cooperation to provide this required bank

information might improve if OPM takes steps to familiarize them with this regulation. We also noted there was no effective process in place for updating vendor information at the time of our review.

Along with our findings, we presented four recommendations concerning the agency's procurement and contracting services in our final report. Among these, we recommended that CSD review past activity reports to determine which IMPAC cards are not commonly in use, notify those cardholders of an intent to suspend, and then do so. OCAS has already implemented this recommendation and has canceled the cards that continue to be unused.

OIG Oversight of GPRA Implementation

The Government Performance and Results Act of 1993, signed by President Clinton on August 3, 1993, was designed to produce improvements in government performance and accountability in federal programs. The Act includes directives for federal agencies and departments to follow regarding strategic planning and performance management processes that emphasize goal-setting, customer satisfaction, and results measurements. Effective implementation of GPRA has an enormous potential to help agencies better manage themselves and assist government leaders in evaluating programs and making decisions on policy, program, and budgeting issues.

GPRA requires all executive branch departments and agencies to submit five-year strategic plans and annual performance plans linked to their respective budgets. Prior to their submission to Congress, however, these annual performance plans (APP) must be reviewed by the Office of Management and Budget (OMB), along with each agency's and department's traditional budget request.

OPM now submits a single document to OMB that contains both the traditional budget information and the agency's annual performance plan. The latter is an aggregate of individual plans regarding performance goals and measures prepared by OPM's various organizational components, including the OIG.

Our office has devoted significant resources, time, and effort in providing oversight of OPM's implementation of GPRA. For instance, from November 1997 through January 1998, members of our Office of Evaluation and Inspections staff reviewed the agency's fiscal year 1999 Congressional Budget Justification (CBJ) document as it related to OPM program offices' individual (APP) submissions. The objectives of our assessment were to determine the following:

- OPM's compliance with the requirements of GPRA.
- Whether goals and measures were measurable, appeared reasonable, and would produce the desired effects.

- Whether data collection mechanisms for measuring performance were in place or being developed.

Since it was not feasible to review all goals and measures in each of the program offices' individual performance plans due to time constraints, we focused our attention on specific goals and related measures from plans of the eight organizations performing functions critical to OPM's core mission.

Using GPRA statutory requirements and guidance developed by OPM, we identified numerous deficiencies in OPM's FY 1999 CBJ/APP document that should be addressed if OPM is to establish an effective system for strategic planning and performance management.

The following are some of the deficiencies noted during our assessment.

- Fifty percent of the individual plans failed to meet GPRA statutory requirements, because a description of the means to be used to verify and validate measured values was not included.

- Plans often did not provide a sufficient description of how goals would be achieved and how to determine when these goals would be met.

- Although strategies were presented, plans often failed to include adequate and complete description of resources required to meet goals.

- Many performance goals lacked quantifiable and measurable qualities required by GPRA.

.

- OPM program offices were inconsistent in their use of fiscal and calendar years.

- Goals and measures often were stated in terms unfamiliar to a general audience.

- Existence of measures often was indicated, but benchmark data was virtually nonexistent in the plans.

In our report, we presented numerous ways OPM could improve its fiscal year 2000 submissions. Some of our comments were incorporated into the current submissions, and the agency has requested and received a draft assessment of that document from the U.S. General Accounting Office. The agency's officials have advised us that they plan to use more of our suggestions in developing the FY 2000 joint CBJ/APP document.

Deficiencies in OPM's Annual Performance Plan Cited

Index of Reporting Requirements (Inspector General Act of 1978, As Amended)

APPENDIX I
Final Reports Issued With Questioned Costs
October 1, 1997 to March 31, 1998

		Number of Reports	Questioned Costs	Unsupported Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	6	$ 9,810,850	$ 27,100
B.	Reports issued during the reporting period with findings	12	78,792,665	42,544
	Subtotals (A+B)	18	88,603,515	69,644
C.	Reports for which a management decision was made during the reporting period:	9	12,332,105	27,100
	1. Disallowed costs		10,201,674	27,100
	2. Costs not disallowed		2,130,431	0
D.	Reports for which no management decision has been made by the end of the reporting period	9	76,271,410	42,544
	Reports for which no management decision has been made within 6 months of issuance	1	2,326,131[1]	0

[1] *Resolution of this item has been postponed at the request of the OIG.*

APPENDIX II
Final Reports Issued With Recommendations
For Better Use of Funds
October 1, 1997 to March 31, 1998

		Number of Reports	Dollar Value
A.	Reports for which no management decision had been made by the beginning of the reporting period	0	$ 0
B.	Reports which were issued during the reporting period	1	11,920[1]
	Subtotals (A+B)	1	11,920
C.	Reports for which a management decision was made during the reporting period:	1	11,920
	1. Dollar value of recommendations that were agreed to by management		11,920
	2. Dollar value of recommendations that were not agreed to by management		0
D.	Reports for which no management decision has been made by the end of the reporting period	0	0
	Reports for which no management decision has been made within 6 months of issuance	0	0

[1]Of this amount, a savings of approximately $9,000 could be realized by the agency over the next five years through timely refund requests related to the Resource Center's on-line services.

APPENDIX III
Insurance Audit Reports Issued
October 1, 1997 to March 31 1998

Subject ***(Standard Audits)***	**Report Number**	**Issue Date**	**Questioned Costs**	**Unsupported Costs**
Capital Blue Cross in Harrisburg, Pennsylvania	10-36-97-008	October 10, 1997	$ 1,576,085	$ 0
Blue Cross and Blue Shield of Delaware in Wilmington, Delaware	10-89-97-040	November 26, 1997	0	
Independent Health Association in Buffalo, New York	QA-00-97-020	December 10, 1997	119,966	
Kaiser Foundation Health Plan Inc.- Hawaii Region in Honolulu, Hawaii	63-00-95-014	December 10, 1997	455,895	
Metropolitan Life Insurance Company in New York City, New York	II-00-96-015	December 12, 1997	3,151,335	
Mutual of Omaha as Underwriter for Rural Carrier Benefit Plan in Charlotte, North Carolina	38-10-95-007	January 13, 1998	603,984	
Blue Cross and Blue Shield of Michigan in Detroit, Michigan	10-32-96-007	January 14, 1998	4,877,193	
TakeCare Health Plan of Ohio, Inc., in Cincinnati, Ohio	R8-00-96-031	January 22, 1998	8,284,083	
Blue Cross and Blue Shield Association in Washington, D.C., and Chicago, Illinois	10-91-96-001	February 6, 1998	15,863,556	

APPENDIX III
Insurance Audit Reports Issued
October 1, 1997 to March 31, 1998

Subject (*Standard Audits*)	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Lahey Clinic in Boston, Massachusetts	JX-00-93-028	February 11, 1998	$ 1,748,909	$
Empire Blue Cross and Blue Shield in New York City and Albany, New York	10-48-95-022	February 13, 1998	3,958,211	42,544
Continental Assurance Company and Claims Administration Corporation as Underwriter/Administrator for Mail Handlers Benefit Plan in Rockville, Maryland and Chicago, Illinois	45-09-93-001	March 19, 1998	33,194,149	
American Postal Workers Union Health Plan in Silver Spring, Maryland	47-00-93-003	March 20, 1998	4,959,299	
Silent PPOs in the FEHBP Review	99-00-97-054	February 26, 1998		
TOTALS			**$ 78,792,665**	**$ 42,544**

Appendix IV
Internal Audit Reports Issued
October 1, 1997 to March 31, 1998

Subject	Report Number	Issue Date	Funds Put to Better Use	Questioned Costs
Internal Control and Related Management Issues from the Audits and Related Work on the Office of Personnel Management's Fiscal Year 1996 Revolving Fund and Salaries and Expenses Accounts Financial Statements	2F-00-97-101	November 3, 1997	$ 0	$ 0
Office of Personnel Management's Fiscal Year 1997 Revolving Fund and Salaries and Expenses Accounts Financial Statements	2F-00-97-102	March 2, 1998		
Office of Personnel Management's Fiscal Year 1997 Benefits Programs Financial Statements	2F-00-97-105	February 27, 1998		

APPENDIX III
Insurance Audit Reports Issued
October 1, 1997 to March 31, 1998

Subject (*Standard Audits*)	Report Number	Issue Date	Questioned Costs	Unsupported Costs
TOTALS			**$ 0**	**$ 0**

Appendix V
Combined Federal Campaign
Audit Reports Issued
October 1, 1997 to March 31, 1998

Subject	Report Number	Issue Date	Funds Put to Better Use	Questioned Costs
The 1994, 1995, and 1996 Combined Federal Campaigns of East Central Alabama, Tuskegee, Alabama	2A-CF-97-023	January 28, 1998	$ 0	$ 0
The 1994, 1995, and 1996 Combined Federal Campaigns of San Diego County, San Diego, California	2A-CF-97-032	March 13, 1998		

TOTALS		**$**	**0**	**$**	**0**